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ABSTRACT

Two hearings held a month apart examine major issues concerning Medicaid benefits in family welfare and nursing home reform. The first set of hearings discusses the proposed Family Welfare Reform Act of 1987 (H.R. 1720), which is intended to replace the Aid to Families with Dependent Children (AFDC) program of the Social Security Act Title IV. Expert witnesses from the legal and social services community discuss ways to assure that women who leave the welfare rolls and return to work can continue to have Medicaid or other health care coverage for themselves and their children. Statistical data are included on two tables and two graphs. The second set of hearings concern the Medicaid Nursing Home Quality Care Amendments of 1987 (H.R. 2270), to amend the Social Security Act Title XIX to change the Medicaid requirements for nursing facilities, other than intermediate care facilities for the mentally retarded. The purpose of the amendments are to improve the quality of care that poor elderly and disabled Medicaid patients receive in nursing homes. New requirements concern the following: (1) service provision; (2) residents' rights; (3) administration; and (4) compliance and sanctions. Thity-nine witnesses from the health care community provided supporting testimony, including case studies. The full text of H.R. 2270 is included. (FMW)

# MEDICAID ISSUES IN FAMILY WELFARE AND NURSING HOME REFORM

# HEARINGS

BEFORE THE

## SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

## COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

INCLUDING

## H.R. 2270

A BILL TO AMEND TITLE XIX OF THE SOCIAL SECURITY ACT TO CHANGE THE MEDICAID REQUIREMENTS FOR NURSING FACILITIES (OTHER THAN INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED) BASED ON RECOMMENDATIONS OF THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES

APRIL 24, AND MAY 12, 1987

**Serial No. 100–73**

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# FAMILY WELFARE REFORM ACT OF 1987

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FRIDAY, APRIL 24, 1987

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. Waxman. The meeting of the subcommittee will come to order. This morning the subcommittee will look at one of the major issues in welfare reform, how to assure that women who leave the welfare rolls and return to work continue to have Medicaid or other health coverage for themselves and their children.

This issue is one of the many raised by the Family Welfare Reform Act of 1987, H.R. 1720, which has been referred to the subcommittee. This bill was introduced by Representative Harold Ford and has been reported out by the Ways and Means Subcommittee on Public Assistance and Unemployment Compensation which he chairs. We are delighted that we are going to be able to hear his views and a description of his subcommittee's actions.

Under current law, families with dependent children who are receiving cash assistance under the AFDC program are automatically eligible for Medicaid. Generally speaking, if a woman loses AFDC benefits because she goes to work and earns enough money to put her over the welfare eligibility level, she and her children will receive an additional 4 months of Medicaid coverage. Of course, nothing in Medicaid is that simple.

There are circumstances under which welfare recipients who return to work receive 9 months continued Medicaid coverage or in some States, 15 months. In other cases, mothers who leave cash welfare can continue to qualify for Medicaid as medically needy, if they live in a State which offers such coverage and if they incur very high medical expenses.

At the request of the subcommittee, the Congressional Budget Office has prepared a staff memorandum summarizing what we know about current Medicaid transition policies. CBO estimates that about half of unmarried women leaving AFDC because of higher earnings do not have any health insurance coverage. CBO notes that even those with private coverage are likely to spend more on health care after their Medicaid coverage ends, because the private coverage is not nearly as good.

7

Finally, CBO concludes that the loss of Medicaid coverage is a disincentive to work, although it is unable to estimate the size of the disincentive.

Without objection, this memo will be inserted into the record at this point.

[The information referred to follows:]

**CONGRESSIONAL BUDGET OFFICE**
**U.S. CONGRESS**
**WASHINGTON, D.C. 20515**

MEMORANDUM April 23, 1987

TO: Andy Schneider

FROM: Jack Rodgers
Steve Long

SUBJECT: Medicaid Transition Issues

In response to your request, this memorandum examines the limited information that is available about two difficult issues. The first concerns the access to health benefits—whether through Medicaid or private insurance—of individuals (and their dependents) who become ineligible for cash assistance from the Aid to Families with Dependent Children (AFDC) program because of an increase in earnings. The second, and closely related, issue is whether or not there is a substantial work disincentive under current law that arises from the potential loss of Medicaid coverage.

## ACCESS TO CARE

The use of health care services by those who are no longer receiving AFDC benefits, a population that is in transition, depends on three main factors—whether they continue to be eligible for Medicaid; whether they are covered by private health insurance; and the extent to which out-of-pocket costs for health care rise, especially for those who have neither Medicaid coverage nor private insurance.

### Medicaid Coverage for the Transition Population

When AFDC recipients, all of whom are eligible for Medicaid, lose their AFDC eligibility because of an increase in earnings, their Medicaid coverage continues for varying periods of time, depending on the level of their earnings and characteristics of their states' programs. Medicaid coverage continues for at least four months regardless of how much is earned. 1/ Data from four states suggest that roughly 4 percent to 8 percent of the average monthly Medicaid caseload is eligible through this transition provision.

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1. The categorical eligibility conditions must still be met, however. For example, the youngest child in the family must still be less than 18 years of age or, if in school, less than 19 years of age.

The four-month transition is lengthened to nine months, provided the recipient's monthly countable income for Medicaid purposes remains below the state's payment standard. 2/ Moreover, this nine-month period may be extended up to a total of 15 months of Medicaid coverage at the state's option. The size of this transition population is thought to be quite small, however.

In states with medically needy programs, Medicaid coverage continues indefinitely for those categorically eligible persons whose family incomes net of medical expenses remain below the protected income levels—usually 133 percent of the AFDC payment standards. Approximately 80 percent of AFDC beneficiaries live in states with such medically needy programs.

Moreover, in states with medically needy programs, any family meeting AFDC's categorical eligibility conditions can receive Medicaid benefits if their medical expenses are large enough relative to their incomes. For example, if the state's payment level is $600 per month, a family with a monthly income of $1,500 and monthly medical expenses of $1,200 would qualify for Medicaid coverage. In this particular circumstance, the family would have to incur out-of-pocket expenses of $700 each month, however. 3/

Finally, states may also extend Medicaid coverage to certain pregnant women, infants, and, beginning in fiscal year 1988, children under five years of age, even if their incomes are above the states' payment levels (or protected income levels in the case of states with medically needy programs). 4/ These higher income-eligibility thresholds cannot exceed the poverty thresholds, however. Such eligibility extensions, authorized by the Omnibus Budget Reconciliation Act of 1986, are expected to be enacted by about half of the states, according to the National Governors' Association. 5/

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2. Countable income is defined as total income less up to $75 in work expenses less the allowed child care deduction less $30 less one-third of the remaining income. The last two aspects of this calculation are often referred to as the "$30 and one-third" reduction.

3. The protected income level would be $800 (1.33 x $600). The family must spend $700 ($1,500 - $800) before their income net of medical expenses would be at the protected income level.

4. Two of these AFDC groups have particularly high medical expenses. Annual Medicaid expenditures are approximately $2,850 per pregnant woman and $920 per infant, compared with $1,220 for the average adult and $640 for the average child.

5. Some of these states are setting the income-eligibility thresholds below 100 percent of the poverty guidelines.

The types of transition described above are all simple cases where income rises and then remains constant, but any specific family's circumstances may vary from month to month because of changes in earnings. Consequently, the length of time that individual families may retain Medicaid eligibility is highly variable. Furthermore, these transition provisions apply only to AFDC recipients losing eligibility because of higher earnings. If AFDC eligibility is lost for other reasons, such as a change in the family's composition, Medicaid coverage ceases at the same time.

## Private Insurance Coverage for the Transition Population

The Congressional Budget Office (CBO) estimates that about one-half of all unmarried female AFDC recipients losing eligibility because of higher earnings receive some other health insurance, for example, through their employers or by purchasing individual policies. 6/ This estimate is based on information about wage rates from a study of AFDC recipients who lost eligibility because of higher earnings, combined with data from the Current Population Survey (CPS) about the health insurance coverage of all workers. The latter information is shown in Table 1, which reports the proportion of employed unmarried women with employment-based health insurance. This proportion rises from 21 percent for women with wages below $3.50 per hour to 90 percent for those with earnings greater than $8.00 per hour.

The CBO estimate is within the range of other studies of private insurance coverage of AFDC recipients losing eligibility because of higher earnings. One study found that private insurance coverage varied widely in five survey sites from a low of 17 percent for children in Dallas to 58 percent for adults in Milwaukee. Another study of AFDC recipients in Hennepin County (Minnesota) found that 60 percent of the children and 70 percent of the adults had private coverage two years after losing AFDC eligibility. Yet another study, based on a national sample, found that roughly 50 percent of family heads were able to replace the lost Medicaid coverage with private insurance.

Even those covered by private health insurance are likely to incur greater costs for their health care after their Medicaid coverage ends, however, because the private benefits are not nearly as generous as those under Medicaid. 7/ Medicaid does not require beneficiaries to pay

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6. Unmarried women include those who never married, are divorced or separated, or are married but not living with their spouses. Approximately 77 percent of women who lose AFDC coverage because of higher earnings are unmarried.

7. For recipients with both Medicaid coverage and private health insurance, Medicaid acts as a "second payer"—that is, it pays all coinsurance and deductible amounts required by the private insurance, as well as for any services covered by Medicaid but not by the private insurance.

deductible or coinsurance amounts and, in addition, pays for services excluded from most other plans. Low-wage workers probably have even less generous plans than the average, although information about the specific characteristics of their plans is extremely limited.

TABLE 1. HEALTH INSURANCE OF EMPLOYED UNMARRIED WOMEN WITH DEPENDENT CHILDREN, BY WAGE RATE a/

| Hourly Wage Rate b/ | Percent Insured By Employer | Percent Covered Only By Medicaid | Percent Without Coverage |
|---|---|---|---|
| Less than 3.50 | 21 | 31 | 45 |
| 3.50 - 3.99 | 32 | 13 | 55 |
| 4.00 - 4.99 | 58 | 10 | 24 |
| 5.00 - 5.99 | 64 | 7 | 18 |
| 6.00 - 7.99 | 76 | 5 | 16 |
| 8.00 and over | 90 | 0 | 6 |

SOURCE: Preliminary Congressional Budget Office tabulations of the March 1985 Current Population Survey (CPS). These estimates are subject to greater error than most CPS estimates because the wage rate questions are only asked of one-fourth of the sample.

a. Unmarried women include those who never married, are divorced or separated, or are married but not living with their spouses. A small proportion of them have insurance that is not employment based; they are not included in this table.

b. This table is limited to the 2.9 million workers who are paid by the hour. Another 1.8 million workers paid on some other basis--for example, by salary or commission--are omitted. The probability of their having employment-based health insurance coverage also rises with earnings.

## Effects of Health Insurance Coverage on Utilization

The subsequent health insurance coverage of families leaving the AFDC program affects their access to providers and utilization of medical services, as well as who ultimately pays their medical bills. Data from the 1980 National Medical Care Utilization and Expenditure Survey suggest that low-income persons with no health insurance are 38 percent less likely to use physician services and 71 percent less likely to be hospitalized than similar persons who are eligible for Medicaid (see Figures 1 and 2). [8] Persons losing Medicaid coverage but obtaining private health insurance experience a smaller, but still noticeable, reduction in their use of physician and hospital services.

Relatively little is known about the effects of this lower use of services on health status, however. On the one hand, some physician and hospital visits for insured persons are of little therapeutic value. On the other hand, data from the Rand Health Insurance Study indicate that lower use of services associated with higher out-of-pocket costs had an adverse effect on those whose initial health status was poor.

## WORK DISINCENTIVES ASSOCIATED WITH THE POTENTIAL LOSS OF MEDICAID COVERAGE

It is widely agreed among observers of the current welfare system that a work disincentive results from the potential loss of Medicaid benefits as earnings rise, but its magnitude is an empirical question about which there is considerable disagreement.

The work disincentive may be large because many low-wage workers—and particularly those who work part time—do not receive health insurance coverage through employment-based policies. As a result, their out-of-pocket costs for health care may rise substantially when they are no longer eligible for Medicaid. This phenomenon is often described as the Medicaid "notch," because in contrast to cash assistance and food stamp benefits, which fall continuously as earnings rise, Medicaid benefits continue undiminished until a certain earnings level has been reached and then coverage stops.

As an example of the notch effect, consider an AFDC mother with one child whose countable income is $4,200 in a state with a payment level of $4,800 and no medically needy program. If she works longer hours and her countable income increases by $50 per month, she will eventually lose $50 per month in cash assistance. In addition, she will lose Medicaid benefits

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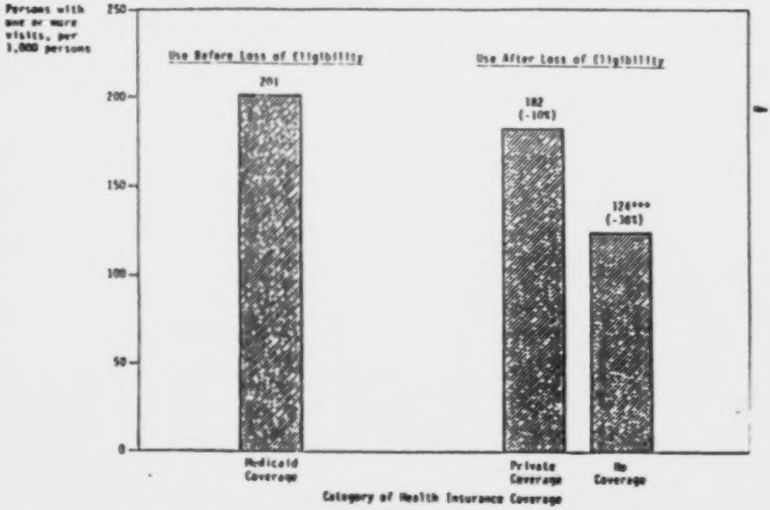
8. Differences such as these also occur for the overall population. Data from the 1977 National Medical Care Expenditure Survey show that persons without health insurance see physicians 35 percent fewer times and spend 48 percent fewer days as hospital inpatients than insured persons (Davis and Rowland, 1983).

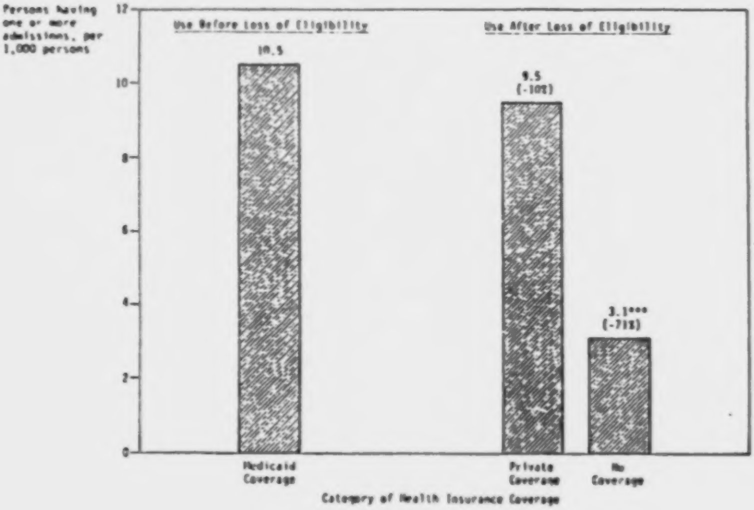
FIGURE 1. ESTIMATED MONTHLY USE OF PHYSICIAN SERVICES BEFORE AND AFTER THE LOSS OF MEDICAID ELIGIBILITY



SOURCE: Stephen H. Long and Russell F. Settle, "Cutbacks in Medicaid Eligibility Under the Omnibus Budget Reconciliation Act of 1981: Implications for Access to Health Care Services Among the Newly Ineligible," HCFA Contract No. 500-83-0058, unpublished report, January 1985.

*** Significantly less than the Medicaid utilization rate at the 99 percent level of confidence for a one-tailed test.

FIGURE 2. ESTIMATED MONTHLY USE OF INPATIENT HOSPITAL SERVICES BEFORE AND AFTER THE LOSS OF MEDICAID ELIGIBILITY



SOURCE: Stephen H. Long and Russell F. Settle, "Cutbacks in Medicaid Eligibility Under the Omnibus Budget Reconciliation Act of 1981: Implications for Access to Health Care Services Among the Newly Ineligible," HCFA Contract No. 500-83-0058, unpublished report, January 1985.

*** Significantly less than the Medicaid utilization rate at the 99 percent level of confidence for a one-tailed test.

that cost an average of $150 per month to provide. For this working mother, the implicit "tax rate" on the increase in her earnings is 400 percent. 9/

On the other hand, aggregate work disincentives may still be small, for two reasons. First, statistics on private insurance among low-income workers probably understate the amount of insurance that has been offered to them through employment-based plans. Since anti-discrimination provisions prohibit employers from offering less generous health insurance benefits to low-wage full-time workers, most low-wage workers in large firms have access to standard health insurance coverage. The fact that some of them choose not to pay their share of the premiums means that they must not value the medical care coverage nearly as much as suggested by its actuarial value. Consequently, the size of the Medicaid notch is probably also smaller than indicated by examples such as the one presented above.

Second, the impact of the work disincentive—although large for some individuals—is limited in aggregate by the proportion of the AFDC mothers that could be expected to change their behavior substantially and seek full-time jobs if it were eliminated. Because most recipients are caring for young children, the behavior of only a portion of AFDC recipients is likely to be affected by the Medicaid notch.

Unfortunately, empirical research on the magnitude of the work disincentive is inconclusive, in part because the necessary data for a definitive study do not exist. They could only be gathered by an experiment, or demonstration, in which some recipients were offered long-term Medicaid extensions and others were not. In the absence of such experiments, most research has compared information about recipients before and after implementation of the Omnibus Budget Reconciliation Act of 1981 (OBRA). 10/ The clarity of this evidence is limited, however, by three factors:

- Because OBRA made many changes in the AFDC program, the effects of any specific one are difficult to separate from the effects of all the others;
- The changes affected both AFDC and Medicaid eligibility, making it difficult to isolate the impact of the Medicaid notch; and
- The economy was changing rapidly during the period of interest.

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9. This "tax rate" represents a loss of $200 ($50 from AFDC and $150 from Medicaid) resulting from an increase in earnings of $50—and 200/50 = 400 percent.

10. Specifically, this act limited the "$30 and one-third" reduction previously used in obtaining countable earnings for calculating AFDC benefits to the four-month period after the recipient started working. The $30 deduction continues for an additional eight months.

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One study, based on aggregate data from the CPS, found that OBRA significantly reduced the labor force attachment of recipients who had previously been active participants in the labor market. In particular, the earnings, employment rates, and number of weeks worked declined considerably more for Medicaid beneficiaries than for other similar poor and near-poor persons. While these results suggest that the Medicaid notch may be important, the impacts of individual aspects of OBRA were not separated. Results from another study, based on a sample of Hennepin County (Minnesota) AFDC recipients who lost eligibility under OBRA, also support the existence of a work disincentive. It estimated that the presence of private insurance for the mother reduced the probability of returning to the AFDC program by about 5 percentage points, but this result may not generalize to the rest of the country. Yet another study, based on a sample of recipients leaving AFDC in five different sites, was unable to find any behaviorial effects related to the provisions of OBRA, although it did not measure the effects on those who did not leave. In short, the preponderance of evidence from these studies is consistent with a work disincentive being associated with the Medicaid notch, but does not provide a basis for estimating its magnitude.

Mr. **Waxman**. It's clear that continuing health coverage is critical to any successful welfare reform strategy. Understandably, welfare recipients who know they will lose their Medicaid will be reluctant to take a job without health coverage, not because they don't want to work but because they want to protect themselves and their children. This is particularly true if they or their children have serious medical needs.

Unfortunately, in many of the jobs which recipients find, health insurance is not offered at all; in others, the insurance is either too expensive or not adequate.

This is not a dilemma that is unique to welfare recipients. There are roughly 37 million uninsured people in this country and about three-fourths of those are employed or are dependents of workers. Solving the problem of the working uninsured is not something we can reasonably expect of welfare reform, but we can expect welfare reform not to make the problem worse by adding to the numbers of working uninsured.

Our first witness this morning was to have been the Honorable Harold Ford, Chairman of the Ways and Means Subcommittee on Public Assistance and Unemployment Compensation. Mr. Ford is the chief sponsor of H.R. 1720, the bill before us today, and has for years fought to improve the welfare system for the poor and working poor families.

Two weeks ago under his leadership, the Public Assistance Subcommittee reported an amended version of H.R. 1720.

Unfortunately, Congressman Ford is unable to be with us today, but we have with us Deborah Colton, Staff Director of the Public Assistance Subcommittee, who will present Congressman Ford's testimony. We are pleased to have you with us. I would like to recognize you at this time to present the Congressman's statement.

## STATEMENT OF DEBORAH COLTON ON BEHALF OF HON. HAROLD E. FORD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Ms. **Colton**. Thank you, Mr. Waxman. Let me begin by apologizing for Mr. Ford who cannot be here this morning.

Changes in the AFDC law always have implications for the Medicaid program. Mr. Ford appreciates the enthusiasm with which you and your subcommittee have greeted this legislation and your willingness to work with him to coordinate jurisdictional interests.

As you mentioned, on April 9th, the subcommittee on Public Assistance and Unemployment Compensation completed its mark-up of H.R. 1720. Within the next few weeks, the bill will be considered by the Full Ways and Means Committee. H.R. 1720 does not cure all of the problems of the welfare system but it does move us in the right direction. It lays the foundation for a new welfare system that says a family's first line of support ought not to be the government. It ought to be a job and where appropriate, child support. Only when these are inadequate should the government step in.

I'd like to take a minute now to give you a brief overview of the major provisions of the bill.

Title I creates a new education, training and work program for AFDC families. We have called the program NETWork and have designed it to provide assistance to those families most likely to be long term welfare dependent. For many families, especially those with children over the age of three, participation will be mandatory.

NETWork will offer those without a high school diploma the chance to get one and will instruct States to provide the full range of training services. The actual participation requirements will be negotiated, one on one, by the State welfare agency and the recipient. It is a program based on mutual obligation and responsibility.

Education and training are only two pieces of the puzzle, however. We know that many welfare recipients who take jobs end up returning to AFDC because the support services they need, most often day care and health insurance, are missing. Title II of the bill establishes a day care transition for working families. These families will be eligible for subsidized day care for 6 months after leaving welfare. This is not a hand out, however. Each recipient will contribute to the day care expense according to a sliding scale that is based on family income. We have also proposed a Medicaid transition which I will discuss in detail in a moment.

Title III of the bill restores the work incentive to the AFDC Program, to assure that those who work are financially better off than those who don't. We do this by changing and simplifying the earned income disregards. Title V includes a series of child support enforcement changes that build on the improvements we made in 1984 and increase the chances that children that are owed child support will actually receive it.

Title VI mandates AFDC for needy two-parent families in which the principal earner is unemployed and requires teenage parents to live at home with their parents in order to qualify for AFDC benefits. We have taken care to identify a number of circumstances when it would be inappropriate for the minor parent to live at home, and we have at the same time eliminated the provision that would count the grandparent's income in determining the child's eligibility.

Mr. Ford shares your concern for continuing Medicaid for these families, even if they are ineligible for cash assistance, and wants to work with you to make sure this is the case.

Title VII of the bill includes several modest benefit improvements. In keeping with the President's desire to leave benefit decisions to the States, we have proposed a 5-year period of enhanced Federal funding for States that choose to increase benefits on their own. In 1993, we establish a minimum State benefit level that is equal to 15 percent of State median income. This approach has the advantage of being tailored to the State economy and cost of living while at the same time making sure that benefit levels in the States now paying the lowest benefits are raised. In short, it targets our resources to the children who need them the most.

Let me turn now to Title IV of the bill, our Medicaid transition. As reported by the subcommittee, the bill provides for a 9-month extension of Medicaid to families who leave AFDC with earnings or child support income. Over 5 years, this has a Federal cost of $735 million. We are concerned, however, that a 9-month extension simply postpones the cliff that parents face when they take a job that does not provide adequate health insurance. Alternatives to this policy should be considered.

An approach of particular interest to us is one that combines a short term guarantee of Medicaid, perhaps between 6 and 9 months, with the opportunity for recipients to purchase Medicaid coverage once the guarantee expires. This buy-in option could be available for up to 3 years with the amount a recipient pays to be based on the cost of coverage or the earnings level.

Mr. Ford hopes you will give some consideration to this approach and that you will work with him over the next few weeks to design a Medicaid transition policy that offers a real benefit to working families who are trying to escape welfare dependence.

That concludes Mr. Ford's statement for this morning. He wanted to leave you with one thought. America's poor children need this bill and they are counting on us to do the right thing. They can't afford high priced lobbyists to bring us their message. It would be a shame to let them down.

Mr. **Waxman**. Thank you very much for presenting that testimony to us.

When H.R. 1720 was introduced, it provided for a mandatory 12-month extension of Medicaid coverage with an option for the States to extend coverage for one additional year. Why did the subcommittee decide to change this policy?

Ms. **Colton**. As introduced, Mr. Waxman, H.R. 1720 cost roughly $12 billion over the first 5 years. When we went to subcommittee mark-up, the Members concluded that this was more expensive than the Committee on Ways and Means could afford, particularly since the Committee has made a commitment to pay for its welfare reform bill. Therefore, we had to cut back on a number of provisions in the bill. I think it would be fair to say that the main reason for cutting the Medicaid extension back was to reduce the cost of the bill.

Mr. **Waxman**. Under the subcommittee's bill, at what level of earnings will women lose their cash assistance benefits and after 9 months, their Medicaid benefits? What does this come to in terms of hourly wage or as a percentage of the Federal poverty level?

Ms. **Colton**. We have not yet calculated the actual breakevens that would occur, that is, the points at which people would become ineligible because of earnings. I think it's fair to say that the breakeven levels would be significantly greater than current law for two reasons. One is that we have changed the earned income disregards. We have made them slightly more generous than current law and that has the effect of keeping people eligible for AFDC and Medicaid for longer than is currently the case.

We have added to that the Medicaid transition policy that guarantees an additional 9 months of Medicaid to families, many of whom are not receiving Medicaid benefits now.

As far as the wage level, what I can tell you is that under current law, in nearly all the States, it's impossible to work full time at the minimum wage and retain AFDC eligibility after 4 months of working. We would make a significant improvement on that, but I can't give you the precise numbers.

Mr. WAXMAN. How much do you think a family at this level of earnings could afford to pay for insurance premiums, co-payments and other out-of-pocket costs?

Ms. COLTON. I don't think our subcommittee discussed what would be reasonable. A number of our members have looked at various ways of requiring a co-payment, including a percentage of the cost of the coverage they would be receiving. Another approach that is of interest, particularly to Mr. Pease on the subcommittee, is to use a percentage of the difference between the point at which they become ineligible for AFDC and their earnings level, so they would only pay a percentage of their increased income based on earnings.

The Members certainly wouldn't want to choose a level that made it impossible for people to actually buy the coverage. I think we would be searching for that middle ground.

Mr. WAXMAN. The 9 month Medicaid continuation policy adopted by the subcommittee is an improvement over the current 4 month extension, but as you noted in your statement, it simply postpones the cliff that working mothers face when they take a job that doesn't provide adequate health benefits.

As an alternative, you suggest a 6 to 9 month Medicaid extension coupled with an option for these mothers to buy continued Medicaid benefits once the automatic extension expires. I'd like to explore this with you.

Do you have any thoughts on how much of a contribution we should expect from the former beneficiary?

Ms. COLTON. I couldn't give you a precise dollar amount but I think it ought to be related in some way to the income of the individual, so you are not asking someone to pay a contribution that is beyond their means and their earnings.

Mr. WAXMAN. Do you have any views as to whether we should require employers to contribute to the cost of any additional coverage?

Ms. COLTON. The subcommittee has not given any consideration to an employer contribution and I would hesitate to comment until I had an opportunity to talk with the Members.

Mr. WAXMAN. What is the thinking behind the 3-year limit on the buy-in option? Many of these women will still have no health insurance option through their employers even at that point.

Ms. COLTON. I think again the main rationale is looking for a way to control costs. I think Mr. Ford would recognize that for some people, you may just be postponing that cliff again for 3 years. It may also be the case, however, that the majority of the people will by that point have access to health insurance, and if that was true, it might not be of as much concern.

Mr. WAXMAN. Thank you for presenting Chairman Ford's testimony. We are going to look forward to working with him and the Members of the subcommittee and with you as we try to fashion an effective Medicaid transition policy.

Ms. COLTON. Thank you, Mr. Waxman.

Mr. WAXMAN. Our next panel will discuss the Medicaid transition issue from the standpoint of working poor families.

Mrs. Shirley Lawson is a working mother of three who is currently in the last month of her 4 month Medicaid extension, after leaving public assistance. Mrs. Lawson is accompanied by her attorney, Ms. Judy Waxman, of the National Health Law Program.

Our other witness is Ms. Laura Rosenthal, an attorney with the Massachusetts Law Reform Institute in Boston, which represents poor and working poor families.

Whenever people talk about welfare reform, they inevitably mention the education and training initiatives that Massachusetts has taken. Ms. Rosenthal will describe the experience in her State with Medicaid transition.

We want to welcome you to our hearing today. Your prepared statements will be made part of the record in full.

I understand, Ms. Rosenthal, that you will be supplementing your statement with affidavits from a number of clients, and without objection, these will be included in the record.

This is a meeting of the subcommittee, but relax. We just want to find out for ourselves what the best decisions are for us to make.

Ms. Lawson, we are pleased to have you with us. We would like to hear from your own experiences what guidance you have for us.

## STATEMENTS OF SHIRLEY LAWSON, WASHINGTON, DC, ACCOMPANIED BY JUDY WAXMAN, MANAGING ATTORNEY, NATIONAL HEALTH LAW PROGRAM; AND LAURA ROSENTHAL, HEALTH ATTORNEY, MASSACHUSETTS LAW REFORM INSTITUTE AND ALSO MASSACHUSETTS HEALTH ACTION ALLIANCE

**Ms. Lawson.** Good morning, Mr. Chairman and members of the committee. My name is Shirley Lawson, and I live at 3803 J Street, N.E., Washington. D.C. I appreciate the opportunity to testify before you today because I want you to understand the problems people face when they lose public assistance.

I recently completed a paralegal training course which helped me get the job I started on January 12. I am now a community education specialist at the Marshall Heights Community Development Organization. My job is community outreach, to let people know about the services we provide and the activities we are involved in which are intended to stimulate business and community development.

I have struggled for many years to try to support myself and my three daughters. I have been on and off public assistance many times. Over the years, I have been in school in different training programs which invariably did not teach me any useful skills, and in a variety of jobs, all of which led me nowhere but back on the public assistance program. I have always wanted to work, but the jobs I could get never paid enough to support my family.

I am hoping that I have finally broken away from public assistance. However, government policies make it very hard for people like me to make ends meet. Although I am bringing in more money to my household, my expenses have gone up dramatically. First of all, because I have a job, my rent subsidy has been cut. As a result, my rent went up from $94 a month to $345 a month. Also, I am no longer getting $176 a month in food stamps.

Another major change is that after next month, my family will no longer be covered by Medicaid. We were able to stay on Medicaid for 4 months after I got this job. That time will run out next month, and there is no way I can get my own health insurance. Medicaid has been very important to my family. It was the one service that we could get that was like what other people could get. We did have decent health care. I used Medicaid for seven major surgeries I have had, and my children used it for their well baby checkups as well as the usual illnesses. They also used the dental care plan. I have one daughter who has asthma, and unfortunately, she is often in need of medical care.

Now that I am losing my Medicaid, I will have no health care coverage. My employer does have health insurance that I can buy. However, I cannot afford the $118 a month for the coverage. In addition to the monthly fee, the insurance plan would require me to pay a yearly $100 deductible plus 20 percent of the first $3,500 of expenses. The plan would also require me to pay $3 for each prescription.

Compared to Medicaid, this plan covers fewer services. Dental and eye care are not covered at all. For example, other services, should we need them, such as home care or mental health services, are very limited in coverage. I receive $502.68 every 2 weeks in salary. From that I must pay rent of $345 a month, $400 a month for food, $60 per month at the laundromat, and $100 or more for my car, which is not in the best of shape.

That leaves me about $50 a month for telephone and other expenses to maintain a household and care for and clothe three teenaged girls and myself. I simply cannot afford to pay $118 a month plus all the other costs for health insurance that covers less than my Medicaid covers.

You may ask what will happen to us if we need health care. What would I do if my daughter has another asthma attack. I would make sure I got her the medical care she needs, and in so doing, I would make a lot of bills I couldn't pay. Then I would probably have collection agencies after me and get my wages garnished. Before long, I would be back to wondering why I was working for so little pay.

If you really want to help the people get off of public assistance and into jobs, you must help them. Medical care coverage is crucial to families, not just for their physical and mental health, but also for financial stability. I urge you to help families help themselves by providing them access to health care benefits.

Thank you very much.

Mr. **Waxman**. Thank you very much, Mrs. Lawson.

Ms. Rosenthal.

## STATEMENT OF LAURA ROSENTHAL

Ms. **Rosenthal**. My name is Laura Rosenthal, and I am a health attorney with the Massachusetts Law Reform Institute, which is a State support center for the legal services programs in Massachusetts.

I appreciate the invitation to speak today concerning H.R. 1720. I am also testifying at the request of the Massachusetts Health Action Alliance, which is a broad coalition of client groups in Massachusetts very much concerned with the problem of the uninsured population.

We are very pleased that the committee is considering expansion of the Medicaid work incentives. I am going to talk about what is happening in Massachusetts under current Federal law, what I see as problems with the Ways and Means Subcommittee approach, and what more Congress and the subcommittee might be doing.

Currently there are three limited provisions for continuation of Medicaid during the transition from AFDC to work. As you have heard, there is the automatic 4-month extension for families who lose their AFDC because of increased work income. There is also an additional 9 months for families who lose their AFDC only because of a time-limited income disregard, which is known as the 30⅓ disregard, and for States that so choose, there is an additional 6 months for some of the same recipients who have lost the 30⅓ disregard. Massachusetts has all of these options, but they are very limited.

The 4-month Medicaid extension which everyone gets is simply not long enough to permit former welfare recipients to make a stable transition to employment. The 15-month extension, the 9 plus 6 months, is more helpful but it is available only to a very limited group whose income is extremely close to the AFDC eligibility level.

As pointed out, you will be getting affidavits from a number of Massachusetts clients. I would like to give you two examples of what happens under the current provisions in Massachusetts, and the individuals I will be naming are people who will be submitting affidavits to you.

Bonnie Marz is a woman whose situation illustrates that the lack of Medicaid really does force people who have left the welfare rolls to go to work back onto welfare. This is a woman who was on AFDC. She got a temporary job with the Post Office, so she lost her AFDC. She was not eligible for the 15-month continuation because her income put her above the level that would have permitted that, so she got only the 4-month Medicaid extension.

The 4 months ran out. She had a child who had chronic ear problems and needed medical care, and she eventually had to quit her job and go back on welfare specifically because of the removal of the transitional Medicaid.

Christina Parks, who is a woman whose affidavit you will also be getting, is a success story. She got 16 months of continued Medicaid. It was essentially the 9 plus 6. She was able to get the Medicaid transition because of the intervention of an advocate. Originally the State was mistakenly going to give her only 4-month transitional Medicaid.

Over the 16 months that she was on Medicaid after leaving welfare, she was able to work her way into a more stable position. She is now earning $15,000 a year. It is not easy for her to live on that, but certainly she is doing considerably better than she did on welfare. Her employer is not paying her full insurance premium, but she is able to pay her share.

She has a child with severe medical problems, including asthma, and she has said that if she had lost her Medicaid after the 4-month transitional period, she simply could not have made it. Now she is someone who says she will never go back on welfare, and the transitional Medicaid made the difference, but it was a long period of transitional Medicaid that really let her improve her situation enough to start buying into an employer's insurance plan.

In general, advocates in Massachusetts working directly with Medicaid clients report that parents going back to work or considering going back to work are much more worried about the loss of medical coverage than they are about the loss of welfare cash benefits. They are willing to have their welfare checks reduced as they go back to work—that is what going back to work is about—but they are torn between the desire to work and the need to make sure their families can get medical care.

This is a particular problem because Massachusetts and all of the States have a tremendous uninsured problem. What we are really talking about is not only the problem of families on AFDC but the problem of a large uninsured population in our country. Many jobs, particularly the kinds of low paying jobs into which welfare recipients are able to go if they do find employment and get off welfare, don't provide health insurance coverage. Many employers who provide marginal insurance rely heavily on part-time workers whom they don't have to insure.

The uninsured population is heavily working poor because of this, and a special commission appointed by the Governor of Massachusetts to study both our health reimbursement system in Massachusetts and the problem of the uninsured has said that there are about 600,000 uninsured people in Massachusetts, many of whom are working poor.

Even employers who do provide health coverage often don't pay for the full premium. You have seen an example of that today. Even Christina Parks, the woman whose affidavit you will be getting who is a success story, still has had to struggle to pay for her share of the premium. Again, this is more the case in low paid jobs, which are the kinds of jobs into which former welfare recipients go. Of course, without health insurance, people who are in low paid jobs cannot generally pay directly for their medical care.

I have submitted a copy of a Massachusetts report called "Up the Down Escalator" as part of my written testimony, which suggests that even at twice the Federal poverty level, people may be able to make ends meet for their routine expenses but don't have the money either to pay for health care directly or to pay for health insurance.

Finally, many people getting off welfare can't directly benefit from private insurance because all nongroup private insurance plans, and even now many employer plans, contain harsh pre-existing condition exclusions. So that if you had had medical conditions for which you have been treated on Medicaid and go on to, say, Blue Cross/Blue Shield in Massachusetts or any of the private insurers, you may find that there is a long period of time during which your actual medical conditions can't be treated due to lack of coverage.

Again, these are problems that affect not only people who get off welfare but people who are working poor or unemployed in all of the States, and that is the reason that we are even discussing this problem of Medicaid transitions, that we have a major uninsured problem.

The present programs, the 4 months and the 9 plus 6 months that are available to some people, make a difference but they don't help enough people. H.R. 1720 as it has come out of the Ways and Means Subcommittee is a start, but there are still some real problems with the Ways and Means version. The 9 months is not enough. The original bill, which allowed for 1 year and another year at the option of the States, was much more realistic, and there are two significant exclusions in the Ford draft which I have noted.

Families in which a family member quits or otherwise limits their work without good cause are excluded from the 9-month Medicaid transition, and families in which a member doesn't cooperate with the State's child support enforcement program are also excluded. As I have detailed in my written testimony, the AFDC program already has similar exclusions, and these exclusions have been the source of tremendous problems and unfairness, and my written testimony goes into that in more detail.

Certainly, whatever the policies for the AFDC cash assistance program, such exclusions have absolutely no place in a Medicaid transition program. The point of a Medicaid transition program is to provide incentives to work by leaving families secure that they will have medical care if they go back to work. Anything that makes that coverage transitional only weakens the incentives to work.

Finally, as I have alluded to in referring to the broad uninsured problem, Congress and the committee will ultimately need a broader approach than just a 1- to 2-year Medicaid transition even as outlined in the original bill. States do have a large uninsured population, and we have to ask what happens to families at the end of any Medicaid transition period, whether it is 1 year or 2 years or 3 years.

Some individuals such as Christina Parks may have employer-sponsored insurance which they can afford; others will not, and we know statistically in Massachusetts how broad the problem is. Many States are beginning to address the broad problem of the uninsured population. For instance, in Massachusetts, business, political and consumer leaders are starting to talk about a subsidized State insurance program with sliding scale premiums which would in part be subsidized by the State, in part subsidized by payroll taxes and other mechanisms.

Whatever the solutions, the State and Federal Government will have to find solutions to the uninsured problem or many low income people, whether they have been former welfare recipients or not, will still have to choose between jobs and medical care. As the States such as Massachusetts start to address this problem, it is essential that the Federal Government participate financially in any such solutions and not just leave them for the States.

[The prepared statement of Mr. Rosenthal and affidavits referred to follow. Exhibits A and B referred to in the prepared statement may be found in the subcommittee files:]

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UNITED STATES HOUSE OF REPRESENTATIVES
ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

Henry A. Waxman, Chairman

Chairman Waxman and Members of the Committee:

Thank you for the opportunity to testify concerning the Medicaid transition provisions of H.R. 1720. I am testifying today on behalf of the Massachusetts Health Action Alliance, a broad coalition of over twenty organizations representing low-income, disabled and elderly individuals; the constituencies of these organizations number in the hundreds of thousands. We are pleased with your interest in expanding the existing Medicaid transition possibilities. I will comment today on the current Medicaid work transitions, on certain problems with the provisions adopted by the Ways and Means subcommittee and on the possibility of a broader approach to the problem.[1]

Current federal law contains some limited Medicaid work transition provisions. These provisions are necessary because many jobs do not provide health insurance. The lack of insurance is a particular problem in the low-wage jobs which many AFDC recipients are able to get when they first work; and it is a particular problem for part-time workers. In the absence of effective Medicaid work transition provisions, there are real disincentives for AFDC recipients to work. Often, without health coverage, they are worse off working than they were on welfare.

The current federal law allows recipients of Aid to Families with Dependent Children (AFDC) to receive Medicaid for four months after losing AFDC because of increased work income or child support. 42 U.S.C. §1396a(a)(1), 42 C.F.R. §435.112. The federal law also allows AFDC recipients who lose their cash assistance because of the loss of a time-limited earned income disregard known as the "$30 and

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[1] This testimony addresses only the Medicaid portion of the proposed legislation and does not implicitly support the concept of "workfare" or mandatory work for welfare recipients.

1/3 disregard" to receive Medicaid for nine months after AFDC termination; states also have the option of continuing Medicaid for this group for an additional six months under some circumstances. 42 U.S.C. §602(a)(37). The nine-month and six-month extensions, where applicable, are not in addition to the four-month extension. Massachusetts AFDC recipients have the benefit of all of these provisions.

Although the current work transition provisions benefit some welfare recipients who go back to work, they are limited. As you will see from affidavits to be submitted, the four-month Medicaid extension is simply not long enough to allow many workers who leave welfare for low-paying jobs to achieve a stable employment situation. It is not uncommon for a former welfare recipient to be forced to quit her job at the end of the four-month transitional Medicaid period because she needs Medicaid coverage for herself and her family. The nine- and six-month extensions have permitted some former welfare recipients to get off welfare and to stay off welfare. But these provisions are available only to certain recipients, essentially those who would be eligible for AFDC if the state continued to apply the so-called "$30 and 1/3 disregard." And even these provisions do not address the more general problem of the uninsured working poor, who sooner or later must choose between working and having health coverage. Uniformly, the report of advocates working with welfare recipients or with low-income former welfare recipients is that families are much more worried about the loss of Medicaid when they go back to work or consider going back to work than about the loss of cash assistance. Particularly when they or their children suffer from chronic medical conditions, parents on welfare often believe, justifiably, that they simply cannot forgo Medicaid coverage, because doing do means forgoing necessary medical care.[2]

The version of H.R. 1720 acted on by the Ways and Means subcommittee begins to address some of the limitations in the current work transition provisions but has significant problems. First, the nine-month Medicaid extension permitted by the Ways and Means version of the bill is simply not long enough. We would anticipate, under these provisions, that many people still would have to leave their jobs and return to the welfare programs at the end of the transitional Medicaid period. The original proposal, which allowed for a year-long Medicaid extension, with the state option of a second year, is somewhat more realistic, although still not a complete solution.

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[2] Up the Down Escalator, a report of the Massachusetts Human Services Coalition, demonstrated that even at twice the federal poverty level a family would not have enough income, on top of monthly expenses, to pay either for health insurance premiums or directly for medical care. Up the Down Escalator: Two Years Later, pp. 12-13, 18, attached as Exhibit "A." Furthermore, many group insurance plans and all nongroup plans impose lengthy pre-existing condition exclusions, which effectively limit the usefulness of private insurance for many families who have just left welfare.

Second, the draft H.R. 1720 language which I have seen has certain significant exclusions from eligibility for transitional Medicaid. The language purports to exclude families in which a member terminates employment, reduces earned income, or refuses to accept employment without "good cause," or fails to cooperate with the state's child support enforcement efforts. The AFDC and Medicaid programs already have similar exclusions and in practice these exclusions have proved to be devastating for many welfare families.[3] Child support "cooperation" involves at minimum revealing the name of the child's father and can require considerably more involvement with the state's efforts to establish paternity and pursue child support. In Massachusetts, the grounds recognized as "good cause" for a woman's failing to cooperate with child support enforcement efforts have been extremely limited; the only grounds recognized by the state have been related to threats of physical or emotional violence to the woman and her children. And the state's verification requirements have further limited these grounds in practice. For example, a victim of rape has been permitted to verify the rape only by police records; a woman too traumatized to report a rape has subsequently been unable to claim "good cause" for failing to cooperate with child support enforcement. The woman's reasonable but unproved fears have not had any legal status; nor have reasonable judgments, not related to domestic violence, that pursuing child support efforts would destroy an already tenuous relationship between father and child. There have also been problems with the *extent* of the involvement which the state has required; for example, the state has sometimes tried to require women to initiate their own court actions. Moreover, the reality, in local welfare offices, is that even though the law allows a "good cause" exception for failing to cooperate with the state's child support enforcement efforts, workers do not routinely explore whether good cause exists. Rather, women are placed in the position of either "cooperating," sometimes at their own risk, or forgoing welfare benefits. Only after a denial or termination is "good cause" raised, and then generally only by a legal advocate if the woman is represented.[4]

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[3] The exclusions in the H.R. 1720 draft language also are drafted far too broadly even for their apparent purpose. The entire family is excluded if *any* family member terminates, reduces, or refuses employment or fails to cooperate with child support enforcement requirements. This is a much harsher exclusion than the current AFDC provisions contain.

Similarly, problems already encountered in the AFDC-Unemployed Parent and Food Stamp programs, which sanction recipients or applicants for quitting a job without good cause, caution against extending such provisions to the transitional Medicaid program. Under the current AFDC and Food Stamp programs, worker do not actually investigate to see whether "good cause" exists. In practice there is no "good cause" provision except for families who are eventually represented by a legal advocate.

Since exclusions similar to the ones contemplated in the present bill have already proved to be fraught with problems and inherently subject to abuse, it is entirely inadvisable to extend such exclusions to the new Medicaid transition provisions. It is particularly inadvisable to do so because the Medicaid transition is supposed to be a work incentive which gives families the security they need in order to join the work force. Any provisions which complicate the availability of Medicaid or make it conditional certainly serve to weaken the work incentive. Furthermore, such requirements must necessarily give rise to reporting requirements which again will be a cause of certain families' "falling between the cracks" and failing to receive Medicaid to which they otherwise would be entitled.

Finally, even if the bill is restored to its original form, with a one-year or two-year Medicaid transition, problems remain. At the end of any Medicaid transition period, many working poor families still will be uninsured, because their employers do not provide insurance, because they cannot afford premiums which they are required to pay under their employers' insurance plans, or because, in the absence of group insurance, they cannot afford private nongroup coverage or are affected by pre-existing condition exclusions. For families' transitions from welfare to employment to be stable, there must be broader solutions to the problem of our large uninsured population.[5] While continuation of families' Medicaid forever is not likely to be the answer, states are independently exploring their own solutions, such as subsidized state health insurance plans available on a sliding scale. In Massachusetts, many government and business leaders as well as consumer advocates are talking seriously about such a possibility. (See "Beyond Welfare," a report of the Massachusetts Senate Committee on Ways and Means, attached as Exhibit "B".) One option, which could contribute significantly to the stability of families' transitions from AFDC to work, would be for the federal government to participate financially in state-subsidized health insurance plans as they develop.[6] In the absence of national health insurance, probably the simplest and most cost-effective solution in the long run, such a solution would at least address the special needs of families struggling to get off welfare without losing essential health coverage.

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[4] Although Massachusetts is now in the process of changing its guidelines for "good cause" and other aspects of child support enforcement, the past experience demonstrates the pitfalls of conditioning benefits on cooperation with the child support enforcement process.

Respectfully submitted,

Laura M. Rosenthal
Attorney

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[5] Massachusetts officials contend that Massachusetts alone has about 600,000 uninsured people. Many of these people are "working poor."

[6] Any such plan would have to be coupled with "deeming waivers" insuring continuing Medicaid coverage for spouses or children who require Medicaid's broader scope of services because of serious medical conditions. To be effective, such plans would also have to meet certain minimum criteria.

## AFFIDAVIT OF BONITA MARZ

I, BONITA MARZ, hereby swear and attest as follows:

1. I live with my seven year-old son, Patrick, at 11 Central Street, Turners Falls, Massachusetts.
2. My son and I have been receiving Aid to Families with Dependent Children (AFDC) and Medical Assistance (Medicaid) since late 1982 or early 1983.
3. In August, 1986, I found a job with the United States Postal Service. I was hired as a temporary, "casual" worker at $5/hour, with no fringe benefits such as sick days or medical insurance.
4. I worked six (6) days per week, an average of 40 hours per week. My gross monthly pay was approximately $866. My monthly take-home pay was $663.
5. In October, 1987, my son and I were terminated from AFDC due to excess income. Because I was not terminated due to loss of the $30 and one-third earned income disregards, I did not receive the extended Medicaid benefits. My son and I received continued Medicaid for four (4) months, or through January, 1987.
6. At the time of my termination from AFDC, I was receiving a monthly grant of $409.00 for 2 people in non-subsidized housing, plus food stamps of $85.00. I receive no child support or medical insurance for Patrick from his father.
7. During the winter, Patrick needed fairly constant medical care due to a bad case of bronchitis and chronic ear infection. I was taking him to the doctor about twice a month

who prescribed regular antibiotic medicine for my son (Moxicyllin and Gantrisin). I did not feel I could afford the cost of either medical insurance for my son or the ongoing medical costs which had been covered by Medicaid.

8. When my son's Medicaid ran out in February, 1987, I felt my responsibility for my child's well-being left me with no choice but to quit my job and go back on AFDC.

9. If I had been able to get extended Medicaid benefits I may have been able to have worked into a more permanent position, with some employer contribution toward health care coverage.

10. I am currently participating in the Massachusetts Employment Training (ET) Program to get off AFDC again in the near future. However, my biggest concern is how I will deal with the loss of medical coverage for my son.

Signed under the pains and penalties of perjury this 5 day of May, 1987.

Bonita Marz
BONITA MARZ

## AFFIDAVIT OF CHRISTINA PARKS

I, CHRISTINA PARKS, hereby swear and attest as follows:

1. I live with my six year-old son, Damien, at 18 Michelman Avenue, Northampton, Massachusetts.

2. I am currently working full-time as a GED (General Equivalency Degree) teacher for Sojourn, an adolescent intervention and training program. My annual salary is $15,000.

3. I was an Aid to Families with Dependent Children (AFDC) recipient from 1982 until I began working full-time in 1985. When I began working on a part-time basis in September, 1984, my monthly AFDC grant was $328.00. In addition, I was receiving $22.00 in Food Stamps, plus Medicaid. My AFDC grant began to decrease starting in December 1984, due to my earnings.

4. In the middle of January 1985, I began teaching 30 hours per week at $5.75 per hour. My average monthly gross pay from January through March was $652.00; my net pay averaged $561.00 per month. I had monthly childcare expenses of $22.00, and transportation to and from work and the childcare facility (45 miles round-trip) cost me $212.00 per month.

5. I was terminated from AFDC in April 1985. My last monthly grant was $142.00.

6. I had just begun full-time employment and my employer was only willing to offer health insurance for me, and not for my son. My son's father does not provide child support or health coverage for his son.

7. I was initially told that my son and I would continue to receive Medical Assistance for four more months. Although I was determined to stay off of AFDC, I was very concerned about the loss of medical coverage for my son, who suffers from chronic asthma and hearing problems that have required ongoing consultation with audiological specialists.

8. Through the intervention of an advocate, I was able to establish that my termination from AFDC was due to loss of the $30.00 and one-third earned income disregards, and therefore I was eligible for the fifteen months of extended Medicaid. During those fifteen months, I was able to work into a more stable employment position.

9. Starting in August, 1986, my employer has been making a substantial contribution to the cost of a family membership with Valley Health Plan, a health maintenance organization providing comprehensive medical coverage for my son and myself, and preventative dental care for my son. I pay $72.00 per month toward the cost of this coverage; my employer contributes the balance toward the monthly premium of $193.49.

10. I feel confident now that I will never go back on AFDC, but the loss of Medicaid after four months would have left my child without medical any coverage. I am not sure I would have been able to remain independent of welfare if it meant jeopardizing my son's health.

Signed under the pains and penalties of perjury.

5/5/87
Date

Christina Parks
Christina Parks

Mr. **Waxman**. Thank you very much.

Ms. Lawson, let me ask you some questions. You have this choice: whether you go to work and lose your Medicaid or whether you don't go to work and stay on welfare, which allows you to stay on Medicaid. You decided to continue working without health insurance rather than return to public assistance in order to continue your Medicaid coverage. That takes a lot of courage, because health care is a pretty expensive proposition. You know how quickly you could be wiped out financially by some medical problem of one of your children.

I think many mothers in your situation would make that same decision. They will want to keep working as long as possible. But the problem with a limited period of Medicaid transition, whether it is 3 months or 6 months or 9 months, is that at some point Medicaid is going to stop. They are then faced with the clear reality that they have a job, they have some money coming in, but they don't have health care benefits and they can't afford to buy insurance.

Congressman Ford suggested that we ought to consider giving families like yours who leave public assistance with earnings automatic extensions of Medicaid for 6 to 9 months, and then giving you an opportunity to buy Medicaid coverage by paying a monthly premium. I want to ask you some questions about that.

Would you be interested in buying Medicaid coverage for yourself and your family if it were available to you?

Ms. **Lawson**. Yes, I would if it would be in the realm that I could afford.

Mr. **Waxman**. If you could afford it. Now, how large a premium do you think you could afford?

Ms. **Lawson**. With the expenses that I have stated here today, at this point I just don't think I would be able to afford to pay a premium.

Mr. **Waxman**. So you would like to buy it but you don't see any price particularly that you could afford.

Ms. **Lawson**. At this point, no. I mean I would like to buy medical insurance. I believe it is a necessity. But as things are in priority, shelter and clothing and food are a little higher on the list, and by the time you get to medical coverage, there is just nothing left.

Mr. **Waxman**. How long period do you think is fair to have Medicaid coverage? Six months? Nine Months? What do you think is fair?

Ms. **Lawson**. I would like to say that I think 1 year to 1½ years would be fair, for the simple reason it would give a person a chance to become established in their job, and if they were going to get a promotion or even to better themselves once they enter the work world, it would give them a chance to just establish themselves and to see in which direction they are going.

Mr. **Waxman**. You've had some job training and your own experience.

What's the longest period of time that you've held a job?

Ms. **Lawson**. The longest period that I've held a job was 3 years, and I was a babysitter.

Mr. **Waxman**. For private families?

Ms. **Lawson**. For a private family, one child.

Mr. **Waxman**. And it was an 8 hours a day job?

Ms. **Lawson**. Ten hours a day.

Mr. **Waxman**. Ten hours. So you were giving them care for their children while they were working?

Ms. **Lawson**. Yes.

Mr. **Waxman**. And what other jobs have you held?

Ms. **Lawson**. Well, I've worked for the Postal Service. I worked there a couple of months.

I've tried to complete my education, and during the course of that, I've held a couple of Work Study jobs which only paid minimum wage.

Before this job, the best job that I've ever had, that I considered, I worked for the Department of Human Services, and it was under a Government program. When they first started to RIF people out, I lost the job and had to go back on public assistance.

If I could have kept that job, it would have cut me from the rolls, I'd say, 5 or 6 years earlier than now.

Mr. **Waxman**. You have three daughters, right?

Ms. **Lawson**. Yes.

Mr. **Waxman**. And they're teenagers?

Ms. **Lawson**. Yes. The oldest daughter just turned 18 in December. The middle child just turned 15 in February. The youngest is 13 in March.

Mr. **Waxman**. And tell me what's happening with them. Are they going to school, or are they working?

Ms. **Lawson**. Yes. My oldest daughter has graduated from high school. My hope for her was to attend college, but she had different ideas.

The youngest daughter, she is in the sixth grade. Through the help of the public schools, I was able to place her in special education. She should be in junior high school now, but she missed a grade or two, because she has a slight case of dyslexia, and it was not diagnosed until later on in her education.

I send my children to school every day. They were keeping her back, and I couldn't understand that, and I went to the school, and I asked them what the problem was, and they told me that she could be tested through the public schools. And thank goodness, I did have Medicaid, because I had to have her hearing and her vision checked before she could be psychologically tested, and that's when they found out that she did have a slight case of dyslexia.

She's been in the Special Education Program for 2 years now, and I'm very proud to say, my daughter is bringing home A's and B's and will be going to junior high school in September.

My middle daughter, she's in junior high school. She is scheduled to graduate to go to high school in September. We're not too sure about that.

I had to go to the school last week, and they have suggested that I seek some type of counseling for her, psychological counseling. So there again, I would need medical coverage to seek this counseling, and without it, she would go without the counseling.

So as I said in my statement, Medicaid has been very important to my family.

Mr. **Waxman**. Are any of the girls married or have children?

**Ms. Lawson.** No children, not married.

**Mr. Waxman.** Well, you know how important health care is and how dependent you are on it. We're going to try to figure out some way to assure that when people go to work, they can do it without feeling that they will lose all their health care benefits. We want to get people to feel that they shouldn't have a reason not to work.

Let me ask, Ms. Rosenthal, what do you think about Mr. Ford's suggestion to allow families who have left AFDC due to earnings to continue their Medicaid coverage by paying a monthly premium?

Based on your work with low-income clients, do you have any suggestions as to whether they would opt for this coverage, and how much in premiums do you think working poor families could reasonably be expected to pay?

**Ms. Rosenthal.** Well, first of all, if such a suggestion were to make sense, it would have to be only after a lengthy Medicaid transition during which full Medicaid coverage was simply available without any charge. I think that the automatic continuation of Medicaid is really a cornerstone of work stability for people who are leaving Medicaid and who will just be beginning to achieve any kind of financial stability.

Remember that the ability to pay for things, whether it's health insurance or anything else, is not just a function of income, but also of resources, and families coming off welfare do not have accumulated savings to any significant degree. In fact, they couldn't have any significant amount of assets to qualify for welfare benefits.

So certainly, if you looked at such a thing, it should only be after, I think, 1-year or 2-year period of automatic eligibility.

The other thing that I would say, though, is that we would have to be very realistic about who really can pay for such coverage. And again, our figures in Massachusetts suggest that at twice the poverty level—that is, a good chunk of the existing working poor—people really do not have the money to pay anything for medical coverage. They really don't have anything on top of their basic monthly expenses.

That's why we have such a large uninsured population in Massachusetts. We have that experience already with people who are working, but find themselves in crises where they don't have medical care.

**Mr. Waxman.** They were working, and they made a certain amount of money. There's a question of rearranging their budget priorities. If they don't have someone in the family who is sick and predictably in need of health care, do you think they'd bother to buy health care, insurance?

**Ms. Rosenthal.** Well, I think that's a very good question. I think many wouldn't.

I don't think it's simply a question of bothering. That is, I think when people get into a higher income level where they don't have to make the same acute choices between, say, clothing and medical care, they probably will and do bother.

**Mr. Waxman.** I understand. But I think if we didn't have our health insurance tied to employment, where the employer offers the employees the opportunity for health insurance and sometimes pays all or part of it, that if people just had their income, and they said, now you can go and take your income and buy whatever you think you need to buy, I think a good proportion of those people that now are covered wouldn't be covered, because they would decide, "Well, if someone gets sick, we'll deal with it then. Why pay money for a problem that's not facing us now. Better to use the money for something else."

And, of course, if you and I looked at it rationally, what they use their money for may not be as intelligent an expenditure as making sure they're covered for their health care needs. But I don't think people always make the most intelligent decisions in allocating their resources. They usually pay for what they want at the moment. Deferred gratification or anticipating problems and thinking them through and dealing in advance of them, that's not the usual way for a lot of people.

Ms. **Rosenthal.** I have a couple of responses. One is that I think you're making a very strong argument for some form of mandatory employer coverage or, in the alternative, national health insurance, which other countries have actually found to be a more cost-effective way to approach the problem.

I would say, though, that in the income range that we're talking about, you don't even have to look at whether people are deferring gratification or what their priorities are. For the most part, people in, say, the 100 to 200 percent of poverty area, can't really pay these sorts of premiums, even if they wanted to. I mean, at that level, the people we're talking about are really, by and large, people who are choosing between food or clothing or paying the utility bills and paying, say, $100 or $50 month premium for health insurance.

Mr. **Waxman.** Let me ask you the reverse side of this point.

You've got a family where they're generally healthy, a young woman—by my standards of young, 30- or 40-year-old woman——

Twenties. Kids. And everybody is generally healthy. The medical problems they have are rare, because there's nothing particularly pressing at the moment, just an occasional problem or other.

How much of a disincentive is it for them to go to work, not to have Medicaid? If they've got a job and they can make some money, wouldn't they rather make some money and have more money to spend?

Ms. Lawson, if people didn't have medical problems in their family, and if they sat down, with an accountant, and the accountant said, "It doesn't make sense for you to work, you can get more cash to spend in hand, but you lose your health care benefits," would they go to work or not? Or do they sit down and really calculate it that carefully?

Ms. **Lawson.** Well, the only way that I can answer that is that I have been faced with that dilemma, not just with the medical coverage, but with the whole AFDC package. And in many instances, it has been—I won't say "profitable," because what they allow you is not a profit—more sensible not to take the low-paying job, because with the package that AFDC offers you, you know that you will have a place to live. You will have some food to eat. You will, if the need arises, be able to have medical care.

And then you look at even a job that pays $5 an hour, I mean, that's not a lot of money when you have a family.

Mr. **Waxman**. You've got to sit on the bus.

Ms. **Lawson**. You sit on the bus.

Mr. **Waxman**. You get up early.

Ms. **Lawson**. Well, not so much. But you have to pay to get on the bus. Then you have to buy new clothes.

Mr. **Waxman**. Yes, but you've got to sit on the bus going long distances. You have to plan your day differently. You have to get there. You've got to hear gripes from somebody who's telling you what to do.

Ms. **Lawson**. Well, like I said, I have been on public assistance for many, many years, more on than off, and when I was younger, I was a ward of public welfare. And all I knew is, I had a responsibility to raise three children, and I had to do it the best way I could.

I enjoy working; I feel that I started late. I've finally gotten a break at what I assume is a decent job. But there have been other job opportunities.

I was offered years ago a GS-2 position in the Federal Government, and I mean, I really got excited when I was offered this position. I said, "This is it, a chance to get off of public assistance." But once I sat down and I thought, well, my rent is going to go up so high. I won't have food stamps. I won't have medical coverage. How much is this worth to me as versus how much is this job worth to me?

I stayed on public assistance.

Mr. **Waxman**. Did you think in terms of maybe starting at that level, but that you'd move up?

Ms. **Lawson**. There was no way I could start at a GS-2 level then and take care of three daughters and have no benefits.

Mr. **Waxman**. As elected officials, we start off with the assumption that we really want people to work. If we raise the AFDC benefits, are we giving you less of an incentive to go to work? Would it be better to lower the benefits, and then you'd have to calculate it the other way—you'd better go to work, because you'd be better off working than not working?

Ms. **Lawson**. To raise the benefits would be a blessing. I've heard people express the view that people like being on public assistance. I mean, what we get as public assistance recipients per month, other people use just for amusement. This is all we have for our livelihood, and I think that to lower the assistance rate would be to put a tremendous burden on a lot of people. To raise the assistance rate would not make it any more attractive to stay on. It would just make it a little bit easier until you could get on with your life.

Mr. **Waxman**. Ms. Waxman—will Ms. Lawson be entitled to any Public Assistance, when her daughters are over the age of majority?

Ms. **Waxman**. Well, she only has one daughter that has just turned 18. She has two——

Mr. **Waxman**. Yes, but when they're all over 18. They should go off the rolls?

Ms. **Waxman**. Oh, yes, at a certain age.

Mr. **Waxman**. And then what happens to them?

Ms. **Lawson**. Well, what happened, when my daughter graduated from high school, there was an immediate panic, because I had not acquired a position yet, so that meant a cut in public assistance. But because they turn 18, it does not mean they leave home.

So I still have the expense of taking care of her. I contacted my social worker, and she explained to me, as long as she was in college, I could receive assistance for her, but the minute she stopped college, then there would be no more assistance for her.

Mr. **Waxman**. You described public assisstance as such a small amount of money that some people use it for amusement, but you've got to live on that amount of money.

How does that make you feel? Do you feel bitter about it, that you're really entitled to more money?

Ms. **Lawson**. Mr. Waxman, every month that I received a first of the month check, I was glad, because I knew, whatever I did, as long as I filled out the papers and met the requirements, I knew that my kids were going to have a place to stay. This is the most important thing.

How could I feel bitter about something that has been the barge that's carried me through?

Mr. **Waxman**. Well, if somebody were giving me some money and it wasn't enough to really help out the way I needed, and they acted like they're doing me such a big favor, I'd feel a little bitter about it.

Ms. **Lawson**. No. I mean, well, I can only speak for myself. I was grateful for what I got, because at least that was something. Anything else, you juggled, and you borrowed, and you did what you had to do to make ends meet. But you knew that was coming; you knew it was coming. You knew that you could pay that rent; you could buy that food.

Since I've gotten off of public assistance, I spend a little more money on food. Things that people take for granted, people on public assistance don't take for granted, such as food. I mean, it was a great thing to be able to have a roast on Sunday. I could sit there and say we ate good. Now, a roast Monday through Friday to a lot of people might not mean a lot. But I mean, we say, hey, we ate good. Roast on Sunday, you know. And having the food stamps, you knew at least 2 Sundays you could have roast.

No, I don't—you could never be bitter about something that has helped you.

Mr. **Waxman**. If you had a chance to make more money than that, how much more money do you think you'd need to make over what you're getting, so you really feel like it would be worth it?

How much money did you say you get on public assistance?

Ms. **Lawson**. Well, when I got off of Public Assistance, I think I was getting $425 a month, which was a raise. For years, we had gotten $399. And when the first raise, $425 came out, I mean, it was like a holiday. Everyone called everyone else: "Guess what? We got a raise," I mean, it was wonderful. The extra money could go a very long way.

Mr. **Waxman**. So you're working now?

Ms. **Lawson**. Yes.

Mr. **Waxman**. How much are you making now?

Ms. **Lawson**. Well, my bring-home pay is $502.68. Before taxes, my yearly salary is $16,000 a year—every 2 weeks, the $502, biweekly.

And I consider myself lucky, because the training program that I came out of was one of the very extraordinary programs through the Department of Employment Services, and I was fortunate enough to be one of the better paid persons that came out of that training program.

Mr. **Waxman**. So you get something like $1,000 a month versus $425, but then you lose your food stamps, your rent subsidy?

Ms. **Lawson**. Right. When I went back for recertification in the housing program, I was astounded. Even though I can afford it, just the mere mention of $375, I mean I'm still turning it over in my mind. It was just more than I ever imagined. But like I say, I have to acquaint myself with the fact now that I can possibly afford that.

Mr. **Waxman**. You have been very good to be here and to go through all of this with me on these really personal questions. It's helped me a lot to put this in perspective. I want to share this with my colleagues as we hear all these speeches about how we are going to put people to work and we are going to do this and we are going to do that. I think it's important to understand that there is a calculation that people do make, in terms of what is in their self-interest. We've got to keep that in mind. People should be helped to have at least the amount to live on, but then give them a little help to get beyond, so they can be self-sufficient.

I thank the three of you for being with us.

Our final panel reflects the State perspective on the issue of Medicaid transition. Mr. Rick Curtis will speak for the National Governors Association; Ms. Barbara Matula will speak for the State Medicaid Program Administrators; Mr. Vernon Smith is the Director of Program Policy for Michigan's Medicaid Program. He will describe an innovative pilot program that the State is planning to develop, health benefits for people who need welfare due to unemployment. Mr. Andy Coburn is with the Human Services Development Institute at the University of Southern Maine, working with the State to develop a Medicaid insurance plan for former AFDC recipients who have lost their Medicaid coverage and have no private insurance coverage through their work. We are pleased to welcome the four of you to our subcommittee hearing this morning. Your prepared statements are going to be inserted in the record in the full, and we would like to ask each of you to summarize, if you would, in no more than 5 minutes.

Mr. Curtis.

## STATEMENTS OF RICHARD E. CURTIS, ON BEHALF OF NATIONAL GOVERNORS' ASSOCIATION; BARBARA D. MATULA, CHAIRPERSON, TASK FORCE ON ACCESS TO HEALTH CARE, AMERICAN PUBLIC WELFARE ASSOCIATION; VERNON K. SMITH, DIRECTOR BUREAU OF PROGRAM POLICY, MEDICAL SERVICES ADMINISTRATION, MICHIGAN DEPARTMENT OF SOCIAL SERVICES; AND ANDREW F. COBURN, ACTING DIRECTOR, HUMAN SERVICES DEVELOPMENT INSTITUTE, UNIVERSITY OF SOUTHERN MAINE

Mr. **Curtis**. Thank you, Mr. Chairman. I would like to note that you couldn't have three more competent folks from the State level than the three sitting next to me. I am privileged to be sitting here with them

As you also know, the Governors' recently adopted policy on welfare reform emphasizes the removal of existing barriers to economic self-sufficiency, and asks for the ability to enhance the ability of parents to do productive work and raise healthy children.

We recognize that parents cannot be expected to give up welfare if access to health care for their families is jeopardized due to loss of Medicaid. While pertinent data is very limited, the available information we know of does confirm the perspectives you heard in the previous panel.

I would point to a study of the effect of the reductions in coverage of AFDC recipients with earned incomes that were implemented due to the 1981 Federal Budget Act. That study found that almost half of those folks going off of the rolls with earned income did not acquire alternative private health care coverage in the short run, and did indeed experience very significant declines in their use of basic health services.

While this data is very impressive, I would note that it's probably an understatement of what happens now, because as you know, the health care marketplace has changed the willingness of health care providers to treat the uninsured. Charity care has, if anything, declined since the early 1980's, so that the 71 percent reduction in hospital use and access that was found then probably is an understatement of what would happen now.

I would also note, though, that the same study found that about half of the newly ineligible population did indeed get private insurance coverage, and that with that private coverage, the use of basic health care services was comparable to what was seen when they were on Medicaid.

It is, I think, important that we design these Medicaid extension policies to allow States to complement and encourage, rather than simply replace longer term private sector coverage.

About three out of four of the 37 million to 40 million uninsured persons in this country, as you know, are workers or dependents of workers. The lack of health care coverage for workers is a particularly acute problem in low wage industries most likely to hire former welfare recipients.

A very high percentage of those workers without coverage do not have an employer-provided benefit plan available to them. Therefore, they are not only faced with having to pay the full premium for an individual policy, but in addition to that, because they are not members of a large group, they face in many States a much higher premium rate.

A number of States are studying or pursuing policies that can reduce the number of workers without health care coverage, and I think that those initiatives hold great promise to provide continuing coverage of workers who are former welfare recipients. Maine and Michigan are basically trying to provide health coverage that is cheaper than what is available in the market to individuals, and to provide some sliding scale subsidies to people withlower incomes. In that way they hope to solve the problem in the longer run, and not simply delay the "cliff" as other approaches might.

We would ask that as you design these Medicaid policy changes, you do so in a way that can facilitate and assist such State efforts to address the problem in the longer run, rather than impede them. I have laid out in the testimony a number of areas where we think some latitude would help. I won't belabor those, other than to mention very quickly the need for: latitude to adopt sliding scale premiums, for example, or other cost-sharing sensitive to people's income levels; some flexibility with respect to benefit designs; the ability to use other administrative mechanisms with Title 19 financing assistance, such as State employer, public employee benefit programs. In the State of West Virginia, I would mention as an example, they are looking at expanding their statewide public employee benefit programs, making that available to employers not offering coverage at this time. That benefit structure is more cost-effective than anything available on the private market.

If, indeed, States are given that kind of latitude, it is our view that the provisions you enact could facilitate significant longer term improvements in health care coverage for former welfare recipients, and just as importantly, for other low income workers and dependents. An example of such a broad strategy that to my knowledge is furtherest along can be found in the State of Washington. I provided some information on that. That legislation passed overwhelmingly one house of the legislature. It's expected by many observers that it will ultimately pass the other house shortly. But at this point, due to some political and budget debates, it's reached a temporary impasse. They are looking at sliding scale premiums for that structure, and as an example, for people with incomes under 125 percent of poverty, they are looking at $10 a month premium for family coverage.

That would be something in addition to their welfare reform initiatives where people within, I think, 135 percent of the current AFDC grant plus food stamps, would continue to receive Medicaid benefits for so long as they are within that income range, and then when they go above that income range, get a 1-year extension, and then past that point, they would, based upon the sliding scale premium, buy into the plan.

I think it is also important to note, as you know, that the budgets aren't exactly rolling with dough at the State level, and that we need to design initiatives so that they are as affordable as possible, and so that we don't preempt State initiatives to cover people in even more need. And as we understand it, the bill out of the Ways and Means Committee would include populations that go beyond former welfare recipients who are now working. The bill would include any others who were on welfare who did have earned income, and that could substantially increase the population receiving this benefit. Some of that population could have substantial incomes and I would hate to see a situation where money that might be used to, for example, extend benefits to a pregnant woman at 70 percent of poverty, instead went to cover people with substantial incomes.

Mr. **Waxman**. Thank you very much, Mr. Curtis, for your statement. We appreciate the summary.

[The prepared statement of Mr. Curtis follows:]

## STATEMENT OF RICHARD E. CURTIS

Mr. Chairman, we greatly appreciate your interest in the Governors' views on extending Medicaid eligibility for newly employed recipients. As you know, at their Winter 1987 meeting, the Governors adopted a policy on welfare reform that emphasizes removing of existing barriers to economic self-sufficiency. The Governors believe that the welfare system should be refocused to enhance the ability of parents to do productive work and raise healthy children. We are submitting a copy of that policy for the record.

The Governors recognize that parents cannot be expected to give up welfare if access to health care for their families is jeopardized due to the loss of Medicaid. Therefore, they support the development of policies to provide transitional health care coverage for people who would otherwise lose Medicaid due to increases in earned income and whose jobs do not provide health coverage.

## Problem

While data directly relating to coverage extensions for welfare recipients are very limited, available information confirms the importance of improved transition policies. A pertinent study estimate effects of the loss of Medicaid coverage under 1981 federal budget legislation, which cut AFDC and therefore Medicaid eligibility for working recipients. This analysis was conducted by researchers at Syracuse University under a Health Care Financing Administration grant. Study findings indicate that almost one-half

(45 percent) of the newly ineligible population failed to acquire alternative health care coverage and experienced significant declines in their use of basic health services. It is estimated, for example, that the loss of Medicaid coverage for this population reduced physician service usage by 38 percent and inpatient hospital service usage by 71 percent. These findings corroborate the fears of Medicaid recipients regarding the loss of health care coverage.

It is likely that the loss of health care coverage is an even greater problem now than five years ago. As Medicare, Medicaid, and private payers prospectively limit their payments to providers, and purchasers increasingly seek to contract with networks of efficient and low-cost providers, much of the informal private-sector subsidy for care of the poor has disappeared. Health care providers are less willing and less able to shift costs of charity care through higher charges to other payers, and have often curtailed the provision of services to the uninsured poor. Because of these changes in the health care marketplace, third-party coverage has become even more critical in providing access to needed health care for lower income individuals.

## Relationship to Private Insurance Coverage

The Syracuse University study mentioned earlier also found that just over one-half (about 55 percent) of the newly ineligible population were successful in replacing Medicaid with private health insurance, and that their use of basic health care services did not significantly decline. More generally, preliminary research (presented to a recent NGA conference on the working uninsured) indicates that one-third of all uninsured person are without coverage for less than four months and another one-third are without coverage for between five and twelve months. Such findings underscore the importance of Title XIX extension policies that allow states to complement and encourage rather than replace private sector coverage.

It is therefore important that federal policies allow states to experiment with health benefit extension approaches other than traditional Medicaid. About three out of four of the 37 million to 40 million uninsured persons in this country are workers or dependents of workers. The lack of health care coverage is a particularly acute problem in lower wage industries most likely to hire former welfare recipients. A number of states are studying or pursuing policies that can reduce the number of workers without health care coverage. Such initiatives hold the greatest promise to provide continuing coverage of workers who are former welfare recipients. Michigan and Maine are two states that are designing such strategies with a focus on former welfare recipients. My colleagues from these states are here to provide you with information gleaned from their own analysis and experience.

## Facilitating Broader State Strategies

States such as Maine, Michigan, and Washington are developing strategies that go beyond simply delaying the loss of Medicaid benefits. The policies you adopt should facilitate such state development of affordable health plan structures. These initiatives are being designed to provide longer term coverage assisted by other financing mechanisms (such as employer and employee contributions, possibly with future state and/or federal subsidies for lower income workers). The traditional Medicaid program structure is probably too expensive and extensive in its scope of coverage to achieve this. Many of the program's characteristics are designed to meet the needs of the very poor. A more affordable structure could meet the most important coverage needs of workers with modest incomes, while providing a transition to longer term health coverage rather than just a one- or two-year extension and termination. Areas where states should have flexibility include:

- o Greater latitude to adopt sliding scale premiums (that vary, for example, based on income and/or duration of time lapsed since going off of AFDC), deductibles, co-payments, and other forms of cost sharing.
- o Flexibility with respect to benefit package design so that a new plan does not have to reflect comprehensive benefits under traditional Medicaid coverage (e.g., the ability of the state to narrow scope and duration of a service or dropping coverage of an optional service normally covered under the state Medicaid plan).
- o The ability to adjust the scope of service and cost-sharing provisions of fee-for-service plans to make their costs equal to more comprehensive benefits offered to this population through cost effective health maintenance organizations or similar plans.
- o The ability to use other administrative mechanisms rather than only Medicaid, such as piggy-backing on public employee benefit programs as proposed in West Virginia for the employed uninsured, or using a "voucher" strategy that gives a choice of affordable private sector plans.
- o The authority to pay or share in the employee's and/or employer share of premium costs for existing employment-based benefit plans as an alternative to a Medicaid extension. States will also need an

expanded or modified "payor of last resort" authority, such as the ability to require that an employed former Medicaid recipient purchase an available employer subsidized health benefit plan.

If states are given such latitude, the provisions you enact could facilitate significant longer term improvements in health care coverage for former welfare recipients as well as for other lower income workers and their dependents. An example of such a broad strategy can be found in the state of Washington. Legislation to provide a basic health plan in five demonstration sites for 30,000 uninsured individuals has passed one house of the Washington state legislature and may shortly pass the other house. The plan would provide services to the state's uninsured population through cost-effective, managed systems of care. Sliding scale premiums would be based on income (e.g., one approach under consideration would be a monthly premium of $10 for those with incomes under 125 percent of poverty, $15 for those in the 125-150 percent of poverty range, etc.). Relatively modest cost sharing provisions are envisioned that would exceed those allowed in federal Medicaid law. The legislation puts a priority on coverage of preventive care such as prenatal, postnatal, and well-child services. Under the state's welfare reform proposal, the "family independence project," persons whose incomes fall within 135 percent of the value of the current state AFDC grant plus food stamps would continue to receive Medicaid benefits. At the point when earnings exceed this level, a one-year extension of benefits under Medicaid will be offered. Medicaid recipients could be given the option of participating in one of the five health benefit plan demonstrations, and after Medicaid eligibility ends would be able to participate in the plan to receive longer term coverage.

At this time, there are no demonstrated models that Congress can draw upon to prescribe a uniform, workable program. We would, therefore, urge you to encourage rather than preclude state innovations. We are finalizing a resource document for states attempting to improve coverage of the working uninsured, and will submit a copy to your subcommittee upon completion. We are now providing you with draft sections of that document which include profiles of relevant state initiatives. We hope that the subcommittee will take this information into account as it develops legislation.

## Fiscal Constraints

It is also critical that Medicaid extension legislation be designed to be workable in the context of federal and state budget constraints. Otherwise, cost increases due to this expansion could force reductions or preclude expansions for populations in even greater need. Data we have obtained from several of the largest Medicaid programs (see attached table) suggest that an extension of coverage would be affordable if it focuses on individuals who lose AFDC and Medicaid benefits because of increases in earnings. This would build on the current four-month extension for such individuals, and would directly address the current work disincentive consistent with welfare reform proposals from NGA, APWA and other groups. However, a mandated extension of Medicaid coverage for all AFDC recipients with earned incomes, such as women who lose eligibility through marriage, would substantially increase potential costs.

We would emphasize that states are not in a fiscal position to fund such significant increases in the state share of Medicaid costs. Due to weakened economies and resulting state revenue declines, 23 states have already been forced to cut spending below levels originally budgeted for this year. The state budget picture will not be appreciably altered by changes in state revenues caused by federal tax reform. Even if states retained the full "windfall" created by federal income tax reforms, the average state windfall would make up only 1.5 percent of state general revenues. This is, in part, because income taxes constitute only 17.4 percent of total state general revenues for the average state (based on fiscal 1985 data). However, under current gubernatorial proposals, the states will return 80 percent of this potential windfall to taxpayers, often in the context of reforms that will make state tax structures more progressive. Thus, Governors intend to return to taxpayers $4.5 billion of the potential $5.6 billion windfall. The remaining $1.1 billion of the windfall is heavily concentrated in states that cannot afford to return the full amount to taxpayers because of severe fiscal stress and poor economic conditions in the oil, mining, and farming sectors.

The impositions of unnecessary Medicaid costs for persons above the poverty line would be particularly unfortunate in light of reductions already made in Medicaid coverage of the poor. This erosion in coverage is most evident for women and children whose Medicaid eligibility has been based on AFDC program standards. For these populations, the income eligibility threshold for a family of three in the average state has declined as a percent of poverty from 71.4 percent in 1975 to 48.9 percent in 1987. State use of the new flexibility Congress has given to states to offset this trend -- by increasing Medicaid eligibility thresholds to as high as the federal poverty line for pregnant women, infants, the elderly, and disabled -- could be substantially compromised by unnecessarily expensive mandates for the non-poor. Many states simply would not be able to both broaden eligibility for such groups and fund expensive mandates for less needy populations.

As you know, the NGA strongly supports giving states the ability to increase Medicaid eligibility levels for poor children. We have actively supported state efforts to improve coverage of pregnant women and infants. Provisions enacted in 1986, however, only allow the coverage of children up to age one this year. The Governors continue to support proposals to allow improved Medicaid coverage of poor children above age one. However, we again emphasize that state policy decisions regarding health care coverage of the poor are, in many states, being made in the context of severely strained budgets. It is therefore important that we focus limited resources on the highest priority populations.

We appreciate the opportunity to convey our perspective, and look forward to working with you to improve both Medicaid eligibility transition policies, and, more generally, health care coverage for the working uninsured.

**AFDC Recipient Use of Four-month Medicaid Eligibility Extension for Those Losing AFDC Benefits Due to Earned Income Increases**

(In thousands)

| | California (Individuals) | New Jersey (Cases) | Massachusetts (Cases) | Ohio (Cases) |
|---|---|---|---|---|
| AFDC Monthly Caseload | 1,533.2 | 124.0 | 84.5 | 248.3 |
| 4-Month Extension Monthly Caseload | 18.8 | 2.4 | 2.4 | 3.9 |
| X3 (12-Month Extension Equivalent) | 56.4 | 7.2 | 7.1 | 11.7 |
| Percent of AFDC Caseload of annualized 4-Month Extension | 3.6% | 5.8% | 8.4% | 4.7% |
| | Avg. monthly for 1985 | Avg. monthly for 7/1/85 to 6/30/86 | Avg. of 3 months Jan.-Mar. 1987 | Avg. monthly for 12 month period ending 3/87 |

New York is refining data on this issue; state Medicaid program officials indicate that tentative numbers are in the same range as the other states listed.

## STATEMENT OF BARBARA D. MATULA

**Ms. Matula.** I will make this as short as I can. I've got a plane to catch.

I am the director of the North Carolina Medicaid Program~~, but~~ one of the hats I am wearing today is that I am chairing APWA's Task Force on Access to ealth Care. This is part of the APWA'S welfare reform initiative, and it's just getting off the ground.

The testimony we have submitted describes the welfare reform proposal; how we hope to strengthen families and move them to self-sufficiency by supporting them during that period of time.

We have not made our final decision, certainly, about how to make that transition from Medicaid to something else a smooth one. But we have looked at and are looking at a lot of options, and if we talk about the goal of making folks self-sufficient and getting them off public assistance, it seems to me that we are then talking of moving them away from Medicaid eventually into some more traditional insurance arrangement. And I know that there are some problems with that, which I am sure we will take up in greater detail.

But what we don't want to do is abruptly drop the newly employed person from the rolls, certainly, or just extend that arbitrarily to a certain time and then again abruptly drop them. So if we talk about the ideal world, the employee that we have now moved from public assistance would get an adequate, affordable insurance package at his place of employment. That's the ideal world. It doesn't exist in all places. So in the interim we are recommending that Medicaid be extended to these families for at least a period of 1 year.

The move then, as we foresee it in our initial thinking, is if we want to go from Medicaid to private insurance, we could help that employee pay his or her share. That assumes, of course, that the employer is offering benefits. But that buy-in provision would certainly begin the transition without heavy cost to the newly employed person.

If no benefits are offered—and I'm working in North Carolina on some indigent care study commission recommendations—I think the State then should take the initiative in creating insurance pools, so that it would be affordable for these small employers to buy into coverage, and again with government assistance, if necessary, to encourage them.

We would be looking at an employee's contribution, whichever the case would be, to employer-based insurance or State-purchased insurance, one that would certainly be affordable. Initially, perhaps, they might pay nothing, giving them months to get used to employment. It could gradually increase over time, but certainly I see a maximum for these folks at the poverty level, and perhaps 200 percent of poverty, of no more than 5 percent of their income as their contribution.

Other options could be the use of State employees' health insurance plans, as an insurer. Certainly enrolling employees in prepaid plans, HOM's, is a possibility, and I am sure we will talk a little later about the idea of using Medicaid as an insurer. I have some mixed feelings about that.

I know you will have some questions, and you will want to move on, but that's our initial thinking about it. It isn't an easy solution, and we don't want it to be a more costly solution.

Mr. **Waxman**. Thank you very much.

Mr. Smith.

[Testimony resumes on p. 62.]

[The prepared statement of Ms. Matula follows:]

# Testimony Of
# Barbara D. Matula
# Chair, Task Force On Access To Health Care
# Of The
# American Public Welfare Association

Good morning Mr. Chairman, members of the subcommittee. My name is Barbara D. Matula. I am the director of the North Carolina Division of Medical Assistance, a position I have held for the past 10 years and I am currently serving as the chairperson of the human service administrators task force on access to Health Care. This task force is part of the American Public Welfare Association's Matter of Commitment project.

Welfare reform has been a very high priority for state and local human service administrators. My colleagues and I believe that we must go far beyond mere tinkering with present public welfare programs and redesign, *fundamentally*, the way we respond to poverty in this country. While the issue of access to Health Care is an essential part of the self-sufficiency agenda for recipients of public welfare, it cannot be the full agenda for poor families and their children. A few statistics make this point:

## Background and Goals

Today one child in four is born into poverty in this country. One child in five lives out his or her childhood in poverty. Among Blacks and Hispanics the numbers are even more stark: One out of two black children is poor. Two of five Hispanic children are poor. Public human service administrators have responsibility within the states for the health and well-being of those who are vulnerable. They oversee the development and

DELIVERY OF SERVICES. THEY HAVE LONG EXPERIENCE AND SPECIFIC EXPERTISE IN THESE AREAS. BECAUSE OF THEIR EXPERIENCE AND OUR LEADERSHIP RESPONSIBILITIES, THEY CAN BE BOTH LEGITIMATE ADVOCATES FOR THE CLIENTS SERVED AND RIGOROUS CRITICS OF THE EXISTING SYSTEM.

WE ALL KNOW THAT SOMETHING CLEARLY IS NOT WORKING. THE AVAILABLE ARRAY OF SERVICES IS NOT ADEQUATE TO THE NEEDS OF AMERICA'S POOR CHILDREN AND THEIR FAMILIES.

RESPONDING TO THE NUMBERS AND WHAT THEY REPRESENT, AND TO OUR RESPONSIBILITIES IN THE STATES, THE HUMAN SERVICE ADMINISTRATORS ADOPTED A POLICY STATEMENT IN 1985 CALLING FOR A RENEWED PUBLIC COMMITMENT TO POOR CHILDREN AND THEIR FAMILIES. A STEERING COMMITTEE WAS FORMED REPRESENTING APWA'S BOARD OF DIRECTORS AND ITS COUNCILS OF STATE AND LOCAL WELFARE ADMINISTRATORS.

THE STEERING COMMITTEE HELD ITS FIRST FORMAL SESSION MORE THAN ONE YEAR AGO. THE GROUP IS ITSELF DIVERSE BOTH POLITICALLY AND GEOGRAPHICALLY. THEY ARE REPUBLICANS AND DEMOCRATS; LIBERALS AND CONSERVATIVES. THEY COME FROM LARGE STATES AND SMALL STATES; THEY SERVE URBAN AND RURAL POPULATIONS.

THE GROUP HAS DEBATED AMONG THEMSELVES THE APPROPRIATE GOALS FOR OUR WELFARE SYSTEM AND THE POLICIES TO ATTAIN THOSE GOALS. THEY HAVE MET WITH A NUMBER OF YOUR COLLEAGUES, WITH CONGRESSIONAL STAFF, WITH OFFICIALS IN THE ADMINISTRATION, WITH OTHER STATE AND

LOCAL GOVERNMENT ORGANIZATIONS, PRIVATE NON-PROFIT GROUPS, AND WITH SOCIAL SCIENTISTS WORKING ON THE WHOLE RANGE OF ISSUES WITHIN THE SOCIAL WELFARE FIELD.

THE GOAL IS STRAIGHTFORWARD: TO REDUCE THE NUMBER OF CHILDREN LIVING IN POVERTY BY PROMOTING SELF-SUFFICIENCY AND STRONG FAMILIES.

BEFORE I DISCUSS THE SPECIFIC RECOMMENDATIONS FOR MEDICAL ASSISTANCE IN THE REFORM OF THE WELFARE SYSTEM, I WOULD LIKE TO TELL YOU ABOUT OUR RECOMMENDATIONS FOR COMPREHENSIVE WELFARE REFORM WHICH ARE CONTAINED IN THE FAMILY INVESTMENT ACT OF 1987 (H.R. 1255) INTRODUCED BY REPRESENTATIVES BARBARA KENNELLY (D-CONN.) AND ROBERT MATSUI (D-CALIF.). MANY OF THESE RECOMMENDATIONS HAVE BEEN INCORPORATED INTO REPRESENTATIVE FORD'S FAMILY WELFARE REFORM ACT OF 1987 (H.R. 1720) WHICH HAS RECENTLY BEEN REPORTED BY THE WAYS AND MEANS SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION.

## BASIS FOR APWA RECOMMENDATIONS

WE BELIEVE THAT INDIVIDUALS BEAR THE PRIMARY RESPONSIBILITY FOR THEIR OWN WELL-BEING AND THAT OF THEIR FAMILIES. IN OUR VIEW, SELF-SUFFICIENCY MEANS FOR AN ADULT, A GOOD JOB; AND FOR A CHILD A NURTURING FAMILY AND SUCCESS IN SCHOOL. WE VALUE FAMILIES AS THE BASIS BUILDING BLOCK OF OUR SOCIETY, BUT WE ALSO REALIZE THAT POLICIES AND PROGRAMS MUST RECOGNIZE THE CHANGING FACE OF

FAMILIES, ESPECIALLY THE INCREASING NUMBER OF SINGLE-PARENT FAMILIES HEADED BY WOMEN. THERE IS A VITAL PUBLIC ROLE AND RESPONSIBILITY FOR SOCIETY'S WELFARE AND EACH INDIVIDUAL HAS CERTAIN RESPONSIBILITIES TOWARD SOCIETY.

THE WELFARE SYSTEM IS COMPLEX AND DYNAMIC. IT REQUIRES POLICYMAKERS TO GO FAR BEYOND TINKERING WITH THE EXISTING STRUCTURE. IT REQUIRES A FUNDAMENTAL REDESIGN OF THAT STRUCTURE. INVESTING IN STRONGER SELF-SUFFICIENT FAMILIES WILL BRING SIGNIFICANT RETURNS; PRODUCTIVE WORKERS FOR A SHRINKING LABOR MARKET, DIMINISHING NEED FOR INCOME MAINTENANCE AND SOCIAL SERVICES PROGRAMS, AND A STRONGER SOCIETY OVERALL.

TO PUT THE CONCEPT OF INVESTMENT AND MUTUAL RESPONSIBILITY INTO ACTION, WE PROPOSE MAJOR REFORMS IN INCOME SECURITY, EDUCATION, AND EMPLOYMENT PROGRAMS. THE KEY COMPONENTS OF OUR FAMILY INVESTMENT PROGRAM INCLUDE THE FOLLOWING:

o A CLIENT-AGENCY CONTRACT REQUIRING ACTIONS BY CLIENTS AND SERVICES FROM AGENCIES ENCOMPASSING EDUCATION, EMPLOYMENT AND STRENGTHENED FAMILY LIFE. WORK OR EDUCATION TOWARD EMPLOYMENT IS REQUIRED OF PARENTS OF CHILDREN OVER 3; WORK-RELATED OR OTHER PART-TIME OUT-OF-HOME ACTIVITY IS REQUIRED OF OTHER PARENTS.

o A COMPREHENSIVE WELFARE-TO-JOBS PROGRAM IN EACH STATE TO PROVIDE THE SERVICES NECESSARY FOR FAMILIES TO MOVE FROM

WELFARE TO SELF-SUFFICIENCY. A STRONG CONNECTION BETWEEN ECONOMIC DEVELOPMENT AND HUMAN DEVELOPMENT SO THAT JOBS ARE AVAILABLE FOR THOSE NOW DEPENDENT ON WELFARE.

- AGGRESSIVE ENFORCEMENT OF CHILD SUPPORT INCLUDING PATERNITY DETERMINATION, VIEWED BY COMMISSIONERS AS A RESPONSIBILITY OF BOTH INDIVIDUALS AND HUMAN SERVICE AGENCIES.

- A NEW NATIONALLY-MANDATED, "FAMILY LIVING STANDARD" USING ACTUAL LIVING COSTS AS THE BASIS FOR CASH ASSISTANCE TO ELIGIBLE FAMILIES. THE "FLS" WOULD PROVIDE A STABLE ECONOMIC BASE AS FAMILIES MOVE TOWARD SELF-SUFFICIENCY AND WOULD REPLACE BENEFITS TO FAMILIES WITH CHILDREN UNDER THE AID TO FAMILIES WITH DEPENDENT CHILDREN, FOOD STAMP, AND LOW-INCOME HOME ENERGY ASSISTANCE PROGRAMS.

- STRONGER PUBLIC SCHOOLS FOR LOW-INCOME CHILDREN INCLUDING BETTER PREPARATION AND STANDARDS TO ASSURE ACADEMIC PROGRESS AND GRADUATION FROM HIGH SCHOOL.

- AVAILABILITY OF HEALTH INSURANCE OR MEDICAL ASSISTANCE TO MEET THE FAMILY'S NEEDS AND SUPPORT MOVEMENT TOWARD SELF-SUFFICIENCY.

- INCREASED AVAILABILITY OF AFFORDABLE, QUALITY CHILD CARE TO MEET CHILDREN'S NEEDS AND SUPPORT FAMILIES WORKING TOWARD SELF-SUFFICIENCY.

- O CASE MANAGEMENT IN OUR HUMAN SERVICE AGENCIES TO HELP FAMILIES ASSESS TOTAL NEEDS AND RESOURCES, TO IMPLEMENT AND MONITOR THE CONTRACT, AND COORDINATE NEEDED SERVICES.

RECOGNIZING THAT OUR GOAL OF REDUCING POVERTY AMONG CHILDREN CANNOT BE REACHED IF THE CURRENT INCIDENCE OF ADOLESCENT PREGNANCY IS ALLOWED TO PERSIST, OUR REPORT ALSO CONTAINS PROPOSALS TO DEAL WITH THE PROBLEM OF CHILDREN HAVING CHILDREN.

WELFARE REFORM SEEMS TO HAVE BECOME A EUPHEMISM FOR NEW WELFARE-TO-WORK PROGRAMS OR OLD WORKFARE PROGRAMS. REFORM OF THE WELFARE SYSTEM MUST BE EXACTLY THAT--A COMPREHENSIVE REFORMULATION OF CASH ASSISTANCE, EDUCATION, HEALTH CARE AND EMPLOYMENT-RELATED POLICIES THAT STRENGTHEN FAMILY LIFE AND PROMOTE SELF-SUFFICIENCY.

THE APWA PROPOSALS PROVIDE SUCH A SWEEPING REVISION. WE HAVE TAKEN AT THEIR WORD ALL OF THE PROPONENTS OF WELFARE REFORM--THE PRESIDENT, THE CONGRESS, THE GOVERNORS, THE ADVOCATES, THE CLIENTS. OUR PROPOSAL GOES BEYOND THE QUESTION OF WHETHER TO INCLUDE THE UNEMPLOYED PARENT IN PUBLIC ASSISTANCE AND WHETHER THE INCONSISTENCIES IN BENEFITS FROM STATE TO STATE SHOULD BE ELIMINATED. IT SHOULD GO WITHOUT SAYING THAT THE ENTIRE FAMILY IN NEED SHOULD BE ASSISTED SO THAT IT MAY ULTIMATELY BE SELF-SUFFICIENT. AND, OF COURSE, THE CASH ASSISTANCE PROVIDED TO FAMILIES SHOULD BE BASED ON THEIR ECONOMIC NEED AND RESOURCES.

WE BELIEVE THAT OUR SOCIAL POLICY MUST ULTIMATELY BE BUILT ON A COMPREHENSIVE SOCIAL INSURANCE MODEL. THIS IS IN PART PRAGMATIC, IN PART PHILOSOPHICAL. OUR PUBLIC PROGRAMS DIRECTED AT ECONOMICALLY ADVANTAGED AS WELL AS DISADVANTAGED INDIVIDUALS HAVE FARED WELL; MEAN-TESTED PROGRAMS HAVE NOT. WE BELIEVE ASSISTANCE TO POOR FAMILIES AND CHILDREN SHOULD BE BASED ON ECONOMIC NEED, NOT ON OTHER MORE ARBITRARY FACTORS. YOUNG PARENTS IN POVERTY WHO HAVE NEVER HAD THE ADVANTAGE OF GAINFUL EMPLOYMENT FACE JUST AS MANY COSTS ON BEHALF OF THEIR CHILDREN AS DO LAID-OFF AUTO WORKERS OR FARMERS DISPLACED BY ECONOMIC FACTORS BEYOND THEIR CONTROL. CHILDREN IN NEED ARE CHILDREN IN NEED.

## MEDICAID AND WELFARE REFORM

ONE OF APWA'S MAJOR RECOMMENDATIONS IS THAT ADEQUATE HEALTH CARE COVERAGE MUST BE AVAILABLE TO FAMILIES DURING THE TRANSITION TO SELF-SUFFICIENCY. THUS, APWA RECOMMENDS THAT MEDICAID CONTINUE TO BE AVAILABLE FOR ONE YEAR FOLLOWING THE LOSS OF CASH ASSISTANCE ELIGIBILITY. THE INTENT IS THAT DURING THIS ONE YEAR PERIOD, THE AGENCY WOULD WORK WITH THE EMPLOYEE AND EMPLOYER TO FIND HEALTH CARE COVERAGE FOR THE FAMILY.

THE OBJECTIVE OF REFORMING THE CURRENT WELFARE SYSTEM HAS BEEN TO DEVELOP AND MAINTAIN THE INDEPENDENCE AND SELF-RELIANCE OF THE FAMILY. AS ANY OF US WHO HAVE CHILDREN KNOW, HAVING HEALTH INSURANCE IS AN ESSENTIAL ELEMENT FOR ANY PARENT WHO WANTS TO

PROVIDE SECURITY TO THEIR FAMILY. FOR THIS REASON THE ASSURANCE THAT SOME FORM OF HEALTH INSURANCE WILL BE AVAILABLE ONCE THE FAMILIES LEAVE THE CASH ASSISTANCE PROGRAMS IS ESSENTIAL. THERE ARE, HOWEVER, A VARIETY OF WAYS TO ACCOMPLISH THIS GOAL, ONLY ONE OF WHICH IS THE EXTENSION OF MEDICAID BEYOND THE TIME A FAMILY IS NO LONGER ELIGIBLE FOR THE CASH BENEFIT PROGRAMS.

THIS MORNING I WOULD LIKE TO DISCUSS THE WAYS IN WHICH MEDICAID IS CURRENTLY EXTENDED, REVIEW THE PROPOSALS TO EXTEND MEDICAID AS CONTAINED IN REP. FORD'S WELFARE REFORM BILL (H.R. 1720), AND THEN OUTLINE SOME OPTIONS WHICH THE STATES BELIEVE WOULD FURTHER ENHANCE THE CHANCES OF DEVELOPING LOW-INCOME FAMILY SELF-SUFFICIENCY.

## CURRENT TRANSITION PROVISIONS

AS YOU KNOW, UNDER CURRENT LAW MEDICAID BENEFITS ARE EXTENDED FOR FAMILIES WITH EARNINGS BEYOND THE TIME THEIR CASH ASSISTANCE HAS BEEN TERMINATED. THERE ARE TWO SITUATIONS IN WHICH THIS HAPPENS. THE FIRST OCCURS WHEN A FAMILY BECOMES INELIGIBLE FOR AFDC DUE TO INCREASED EARNINGS, OR AN INCREASE IN HOURS WORKED. IN THIS SITUATION MEDICAID BENEFITS ARE AUTOMATICALLY EXTENDED FOR A PERIOD OF 4 MONTHS.

THE SECOND EXTENSION RELATES TO THE EARNED INCOME DISREGARDS UNDER AFDC. FOR THE PURPOSE OF DETERMINING AFDC ELIGIBILITY, THE FIRST $30 OF EARNED INCOME IS DISREGARDED FOR 12 MONTHS AND ONE-

THIRD ON ANY ADDITIONAL INCOME IS DISREGARDED FOR THE FIRST 4 MONTHS. ANY FAMILY WHICH BECOMES INELIGIBLE DUE TO THE EXPIRATION OF EITHER OF THESE DISREGARDS AUTOMATICALLY RECEIVES MEDICAID BENEFITS FOR AN ADDITIONAL 9 MONTHS, AND UP TO 15 MONTHS AT THE OPTION OF THE STATE.

THESE PROVISIONS WERE PUT IN PLACE FOR THE PURPOSE WE ARE DISCUSSING TODAY; TO PROVIDE A SMOOTH TRANSITION FROM PUBLIC ASSISTANCE TO SELF-SUFFICIENCY. INTERESTINGLY, STATES HAVE FOUND THAT ONLY A SMALL NUMBER OF FAMILIES CONTINUE TO RECEIVE MEDICAID BENEFITS UNDER THE DISREGARD EXPIRATION PROVISION, AS COMPARED WITH THE NUMBER RECEIVING 4 MONTH EXTENSIONS AFTER THEY LEAVE THE CASH ASSISTANCE ROLLS. I BELIEVE MANY PEOPLE HAVE ASSUMED THAT MOST FAMILIES LEAVING AFDC WERE GETTING AT LEAST 9 MONTHS COVERAGE.

## H.R. 1720

WHAT H.R. 1720 CALLS FOR IS A LENGTHENING OF THE 4 MONTH EXTENSION OF MEDICAID BENEFITS. H.R. 1720 WOULD CONTINUE SUCH BENEFITS FOR A PERIOD OF 9 MONTHS -- APWA HAD CALLED FOR A ONE YEAR EXTENSION IN ITS "ONE CHILD IN FOUR" REPORT, WHICH WAS PREVIOUSLY SUBMITTED TO THE SUBCOMMITTEE. I SHOULD ALSO POINT OUT THAT THE H.R. 1720 PROVISION IS NOT AN EXACT EXTENSION OF THE CURRENT 4 MONTH PROVISION. CURRENT LAW CALLS ON THE CONTINUATION OF BENEFITS IF THE FAMILY BECOMES INELIGIBLE DUE TO AN INCREASE IN EARNINGS, OR THE HOURS A PERSON WORKS, OR CHILD SUPPORT

COLLECTION. H.R. 1720 CALLS FOR AN EXTENSION OF BENEFITS TO WORKING FAMILIES WHO LEAVE THE AFDC PROGRAM WITH EARNINGS. THIS NEW PROVISION ENCOMPASSES A BROADER CATEGORY OF FAMILIES.

THE PROBLEM WITH CURRENT POLICY AND MANY OF THE PROPOSALS TO DATE IS THAT THEY ONLY DELAY THE INEVITABLE SUDDEN LOSS OF ALL MEDICAID BENEFITS. IT IS ASSUMED THAT AFTER A MODEST AMOUNT OF TIME, THE FAMILIES RESOURCES OR EMPLOYMENT SITUATION WILL CHANGE TO THE EXTENT THAT PRIVATE HEALTH CARE COVERAGE WILL BE AVAILABLE WHERE IT WAS NOT WHEN THE FAMILY FIRST LEFT THE CASH ASSISTANCE ROLLS.

BUT IF ONE THINKS ABOUT THE REALITY OF THESE FAMILIES' SITUATIONS -- LOW-WAGE EMPLOYMENT, EMPLOYERS WHO DO NOT PROVIDE HEALTH CARE BENEFITS, LIMITED UPWARD MOBILITY -- THE ASSUMPTIONS BEING MADE BY THE CURRENT PROPOSALS ARE QUITE A LEAP OF FAITH. IT IS VERY LIKELY THAT UNLESS THE HEAD OF THE FAMILY HAS GOTTEN A JOB WITH AN EMPLOYER WHO PROVIDES HEALTH INSURANCE AND/OR RECEIVES A SIGNIFICANT INCREASE IN INCOME DURING THE INTERIM PERIOD, THE FAMILY IS IN THE SAME DILEMMA THAT WAS AVOIDED WHEN THEY FIRST LEFT THE CASH PROGRAM. THEY STILL FACE A BIG CLIFF. THEY ARE STILL IN SIGNIFICANT DANGER OF RETURNING TO THE WELFARE ROLLS BECAUSE THE LOSS OF HEALTH CARE BENEFITS OUTWEIGHS ANY ADVANTAGES THEY HAVE DERIVED FROM SEEKING EMPLOYMENT AND INDEPENDENCE.

## SUGGESTED ALTERNATIVES

A MORE REALISTIC APPROACH TO THE PROBLEM IS NEEDED--ONE THAT TAKES INTO ACCOUNT THE REALITIES LOW-INCOME FAMILIES FACE. A MORE CREATIVE SOLUTION IS NEEDED TO ENSURE THAT THESE FAMILIES WILL SUCCEED IN BECOMING SELF-SUFFICIENT. SUCH A SOLUTION SHOULD MEET THE FOLLOWING CRITERIA:

- ELIMINATE THE "CLIFF" AND PROVIDE FOR A MORE GRADUAL TRANSITION FROM FULL MEDICAID BENEFITS TO PRIVATE COVERAGE;

- MOVE THE INDIVIDUALS AWAY FROM MEDICAID TOWARDS MAINSTREAM TYPE COVERAGE, JUST AS OTHER PROGRAMS ARE MEANT TO GET INDIVIDUALS OUT OF THE WELFARE ENVIRONMENT AND BECOME INDEPENDENT;

- PROVIDE FAMILIES WITH ALTERNATIVES OF BASIC HEALTH CARE COVERAGE TO INSURE THAT THEIR FAMILIES HAVE ADEQUATE CARE.

THE APWA TASK FORCE ON ACCESS TO HEALTH CARE WHICH I CHAIR REPRESENTS THE COLLABORATIVE EFFORTS OF HUMAN SERVICE ADMINISTRATORS AND MEDICAID DIRECTORS TO EXPLORE ALTERNATIVE PROPOSALS THAT MEET THESE CRITERIA. WHILE WE ARE JUST BEGINNING HAVING DISCUSSIONS IN EARNEST AND HAVE REACHED NO FORMAL DECISION, WE DO HAVE SEVERAL SUGGESTIONS FOR THE SUBCOMMITTEE TO CONSIDER DURING THESE DELIBERATIONS.

STATES COULD PROVIDE A MUCH SMOOTHER TRANSITION FROM WELFARE TO WORK IF THEY WERE ALLOWED THE OPTION TO PURCHASE PRIVATE HEALTH INSURANCE USING MEDICAID FUNDS FOR INDIVIDUALS ENTERING EMPLOYMENT AND GOING OFF THE CASH ASSISTANCE ROLLS. SUCH ARRANGEMENTS COULD BE CONSTRUCTED IN A VARIETY OF WAYS, SOME OF WHICH WOULD INCLUDE EMPLOYER AND EMPLOYEE CONTRIBUTIONS.

IN THE CASE WHERE THE WORKER FINDS EMPLOYMENT WITH AN EMPLOYER WHO PROVIDES HEALTH INSURANCE, THE STATE COULD SIMPLY "BUY-IN" TO SUCH COVERAGE, WITH THE EMPLOYER MAKING THE SAME CONTRIBUTION AS THEY DO FOR OTHER EMPLOYEES. IF THE EMPLOYER DOES NOT OFFER HEALTH INSURANCE, THE HEALTH AND WELFARE AGENCIES SHOULD GET INVOLVED BY EITHER ASSISTING THE EMPLOYER IN OBTAINING INSURANCE OR BY SETTING UP PRIVATE INSURANCE ALTERNATIVES. WE BELIEVE STATE AGENCIES HAVE AN OBLIGATION TO GET ACTIVELY INVOLVED IN ASSISTING FAMILIES DURING THE TRANSITION PERIOD, BUT WE NEED SOME LATITUDE TO ACCOMPLISH THESE TASKS.

STATES SHOULD ALSO BE ALLOWED TO REQUIRE CONTRIBUTIONS FROM WORKERS IF THEIR INCOME IS ABOVE A CERTAIN LEVEL, E.G., THE FEDERAL POVERTY LEVEL. ANY SUCH CONTRIBUTION SHOULD BE BASED ON A GRADUATED PREMIUM SCHEDULE NOT TO EXCEED A CERTAIN LEVEL OF THE WORKER'S TOTAL INCOME, SUCH AS 5 PERCENT. SUCH CONTRIBUTIONS COULD ALSO VARY OVER TIME. WORKERS COULD BE REQUIRED TO CONTRIBUTE VERY LITTLE, IF ANYTHING, IN THE FIRST FEW MONTHS AFTER THEY LEAVE THE WELFARE SYSTEM, AND THEN CONTRIBUTE GREATER AMOUNTS OVER TIME. HAVING THE WORKER CONTRIBUTE REASONABLE

AMOUNTS TOWARDS THEIR FAMILY'S HEALTH CARE WOULD ASSIST IN THE MOVE TOWARDS SELF-RELIANCE.

FURTHER VARIATIONS ON THIS PROPOSAL WOULD BE TO ALLOW STATES TO INCLUDE CLIENT FAMILIES IN THEIR STATE EMPLOYEE HEALTH PLANS, OR TO ENROLL FAMILIES IN PREPAID HEALTH PLANS.

IN ORDER TO PROTECT THE FAMILIES INVOLVED, MEDICAID FUNDS SHOULD ONLY BE USED TO PURCHASE HEALTH INSURANCE THAT MEETS CERTAIN BASIC STANDARDS. SUCH STANDARDS NEED NOT BE ELABORATE TO ENSURE THAT THE FAMILY RECEIVES A GOOD STANDARD HEALTH PACKAGE.

THE STATES BELIEVE THAT THERE ARE SEVERAL BENEFITS TO ALLOWING THESE ALTERNATIVE APPROACHES OVER A STRAIGHT EXTENSION OF MEDICAID BENEFITS. THESE BENEFITS INCLUDE:

- MOVING FAMILIES INTO A MORE TRADITIONAL PRIVATE HEALTH CARE ARRANGEMENT, AWAY FROM PUBLIC ASSISTANCE;
- GRADUALLY INCREASING THE WORKER'S RESPONSIBILITY RATHER THAN DROPPING THE RESPONSIBILITY FOR ACQUIRING HEALTH CARE COVERAGE ON THE INDIVIDUAL TOTALLY AND ABRUPTLY;
- SIGNIFICANTLY REDUCING THE STATE AND FEDERAL FINANCIAL CONTRIBUTION FOR THE SAME TIME PERIOD.

IT SHOULD BE OBVIOUS THAT MUCH OF WHAT I HAVE DISCUSSED HAS BROADER IMPLICATIONS. BY IMPLEMENTING THESE PROPOSALS A STATE COULD ESTABLISH THE MECHANISM FOR DEALING WITH THE GENERAL PROBLEM OF THE UNINSURED. THAT SUBJECT IS BEST LEFT TO DISCUSSIONS AT ANOTHER HEARING, BUT THE SUBCOMMITTEE SHOULD ANTICIPATE THAT THESE APPROACHES WILL HAVE POSITIVE IMPLICATIONS.

THANK YOU FOR LETTING ME TESTIFY THIS MORNING ON SUCH AN IMPORTANT TOPIC. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

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## STATEMENT OF VERNON K. SMITH

Mr. SMITH. Thank you, Mr. Chairman. I am Vernon Smith with the Michigan Medicaid Program. The value of health insurance coverage is self-evident, for those of us who have been working in this area, and when you look at the poor who have greater health problems than those who are non-poor.

In Michigan, the most telling statistic as we began to look at this area was one that came out of our employment program. We found that of those persons who were taking jobs through the employment service, about half found jobs which had health insurance, and about half took jobs in which there was no health insurance. But when looking at those persons who came back onto public assistance, we found that 80 percent of those persons were in jobs with no health insurance at all. So we began to try to see if there was something that we could do to strengthen the possibility persons who took jobs would continue in those jobs, and that by providing some of the health insurance coverage, perhaps we could help achieve that objective.

The problem, of course, as has been described already this morning, is that within current policy, there really is no transition coverage. True, there are some Medicaid extensions; 4 months, 9 months, up to 15 months. But in practice, at least in Michigan, those extensions don't seem to be fully taken advantage of, for whatever reason. We find that there are about 25,000 ADC persons who take jobs and leave public assistance in Michigan, but at any point in time only about 3,500 are actually on Medicaid in one of those extension programs.

Part of our response to this in Michigan has been to design something we call a health care access project. We were fortunate to win partial support from the Robert Wood Johnson Foundation for this project, and it's being implemented in conjunction with an organization known as the Michigan League for Human Services.

The target population for this is persons who leave our general assistance or ADC rolls to take a job in which there is no health insurance, or whose Medicaid extension has run out. We designed a plan which is kind of quasi-Medicaid, quasi-private insurance. It is something we call a one third share plan, because it's designed so that the cost of it is shared equally by three parties: the employee, the employer, and a State subsidy.

The plan right now is in its very early stages. It's targeted for implementation in the fall. We are in the site selection process, and that is going to take place early next month.

We know that we have some important questions to answer, though, with this. We don't know, for example, whether the employees will actually participate at a cost of $20 per month. We don't know if employers will participate, particularly those who have not provided health insurance to generally low wage employees up to this point in time. We don't know if providers, particularly case managed providers whom we want to target for participation under this, will actually participate at rates that are affordable, based on the rates that have been paid up to this point in time. Will the coverages be adequate, based on a somewhat more restrictive benefit package, than exist in the mainstream of fairly comprehensive Medicaid coverage right now? We plan to have some co-pays and deductibles. Will these be affordable? Will they achieve the utilization control objectives that are usually part of having co-pays and deductibles?

And most importantly, or at least very importantly, will the plan turn out to be affordable for those who are paying the bill?

Transition coverage such as we are talking about on this pilot project simply is not available within the authority currently existing within the Medicaid statute. We would propose replacing the existing Medicaid extensions with one which would allow a State to design a step-down program. We talk about the "cliff" or the "notch effect" which occurs now when there is a precipitous loss of Medicaid coverage. It would be appropriate to talk about something which would allow some kind of a continuation and then a "step-down" as persons move from public assistance into mainstream private employment.

In looking at this, perhaps we would want to look at differences in coverage, for example. Medicaid has certain coverages which are mandatory, such as skilled nursing care, which perhaps would not be necessary. It might be possible to place additional limitations on in-patient hospital care.

We would, of course, want to continue full coverage for pregnancy and primary care, and perhaps something such as ESPT for kids. We think it would be appropriate to consider larger co-pays and deductibles, approximating local standards for private employers.

This would include nominal co-pays which are not allowed through Medicaid on such services as physician services, emergency room, outpatient hospital, and prescribed drugs. It may be even worthwhile to talk about some kind of a co-insurance, such as $100 per in-patient hospital stay.

It would probably be appropriate to talk about some limits on eligibility. Certainly coverage should extend up to the poverty line, but in order to ensure that the credibility of the program would be preserved in the eyes of the public, some upper limit at two or three times the poverty line would be appropriate.

We would want to have latitude to include employee contributions, perhaps on a sliding scale based on time of employment or income, and employer contributions. I think we would also like to be allowed to have some restrictions with regard to freedom of choice, so that we would be able to utilize exclusive providers, preferred providers, managed care providers, or other delivery systems, which would perhaps be more cost-effective.

The key point is that for this transition coverage to be effective, States need the latitude to design a program. I think the key recommendation is that States be given the latitude to design a program which is uniquely applicable to that State. We, of course, have well over 50 different Medicaid jurisdictions now, each one with a different program. Part of that is appropriate and reflects differences which occur around the country, and certainly that which would be appropriate for Michigan would not necessarily be appropriate for California and New York.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Smith follows:]

# STATEMENT OF VERNON K. SMITH

## I. Introductory Statement

Mr. Chairman and members of the Committee:

My name is Vernon K. Smith. I am the Director, Bureau of Program Policy, for the Medical Services Administration (the Medicaid Program), Michigan Department of Social Services. Formerly, I was budget director for the Michigan Department of Social Services.

I also currently serve as director of the "Health Care Access Project," a new demonstration project partially funded by the Robert Wood Johnson Foundation's Health Care for the Uninsured Program.

I am here today as an analyst, representing the Michigan Department of Social Services, to discuss issues which arise in trying to strengthen the effectiveness of welfare-related work programs through a modified Medicaid health benefit which would extend beyond the end of eligibility for welfare cash assistance.

## II. The Value of Health Coverage to Employment

For the poor, who face health problems to a greater extent than the non-poor[1], the importance of health insurance coverage to employment would seem self-evident.

The importance of health coverage is underscored by the results of a recent study conducted by the Bureau of Employment Services of the Michigan Department of Social Services(2). This study found that persons who left AFDC because they were employed were about as likely to have taken a job in which there was employment-related health insurance (54%) as to have taken a job without health insurance (46%). However, of those who lost or left the job which got them off of public assistance, over 80% were in jobs with no health insurance.

Other factors, such as the type of job or the rate of pay may have been factors in the loss of these jobs. Clearly, however, there is a strong and significant association between the lack of health insurance and the loss of employment, among AFDC recipients.

The study concludes: ". . . over half of all responses by the employed [subsamples] cite the lack of health insurance as a major problem, followed by difficulties with transportation and child day care. For those respondents who had become unemployed, lack of health insurance and transportation problems account for about two-thirds of all comments."

## III. The Problem With Current Policy

The problem with current policy is that the Medicaid health benefit coverage is tied directly to eligibility for AFDC or SSI. In general, when a recipient of public assistance gets a job or leaves the welfare roles, all too often -- over half the time in Michigan -- the success of employment and independence from welfare is countered by the precipitous loss of the Medicaid, with no other health benefit coverage to replace it.

This is the so-called "cliff" problem, or the "notch effect."

There are Medicaid extensions now in place for up to 15 months. These Medicaid extensions are supposed to be automatic, based on earnings, hours worked, or end of eligibility for the "$30 and 1/3" earned income disregard. In practice, at least in Michigan, the extensions seem to be seldom used. Recipients seem not to request this benefit, and workers, who have enough to do already, seem not to mention or initiate it. Michigan currently averages 3,500 cases per month in the special Medicaid extension categories, while over 25,000 cases per year are coded as closed to employment and would presumably be eligible for the extended coverage.

## IV. The Challenge: Transition Health Coverage

The challenge and the objective then is to design a health benefit coverage which will facilitate a successful transition from public assistance to work.

To be successful, this health benefit should be one which:

- avoids the "cliff" of precipitous loss of coverage when leaving AFDC due to employment
- will contribute to lasting self-support, not a return to welfare assistance
- will be used by eligible recipients
- will be affordable -- to states, to federal government, to employees who were on welfare

## V. An Example: Michigan Health Care Access Project

Under the auspices of the Robert Wood Johnson Foundation's Health Care for the Uninsured Program, the Michigan League for Human Services and the Michigan Department of Social Services are jointly carrying out a demonstration project in an urban and a rural site over the next two years.

A key feature of this project is the "One-Third Share Plan." The "One-Third Share Plan" is designed to provide an affordable health benefit to persons who leave General Assistance or AFDC due to employment, whose jobs provide no health insurance and any other coverage (such as a Medicaid extension) is exhausted. Under this plan, the cost of care, in some kind of a managed care system, is to be shared equally in one-third shares by the employee, the employer and the state.

In other words, it is a subsidized health insurance plan which will be made available to persons who work their way off of welfare, and to the employers who hire them.

In carrying out this project, we will be answering some important questions which are important to the issues before this committee today. For example:

- will low wage employees pay one-third the cost -- perhaps $20 per month per person -- to participate in such a plan?
- will employers who hire welfare recipients, who have not provided health insurance before, buy into this subsidized plan?
- will case management providers, such as HMOS, be willing to participate in this plan?
- will the rates be actuarily sound?
- will a modified coverage provide adequate care?
- will the copayments, deductibles and benefit limits lead to an affordable program?

## VI. Medicaid Authority Required to Provide Transition Health Coverage

Health benefit coverage which would provide the best transition to work would, for most states be different from traditional Medicaid coverage.

The target population for this transition coverage is limited to persons who are earning enough that they are above welfare benefit levels -- although not necessarily above poverty levels.

Therefore, the benefit package can be designed to "step down" the cliff, rather than simply postpone the fall to a future date at the end of a Medicaid extension.

To do this will require new authority under Title XIX of the Social Security Act. This authority should replace the existing Medicaid extensions with provisions which provide the latitude for states to adopt the following:

- Amount, duration and scope of benefits: Benefits should be different from traditional Medicaid, and more like mainstream work-related insurance. For example, coverage might not include skilled or intermediate nursing home care, or might include specific limits on inpatient hospital care. Coverage for full primary care and pregnancy-related care, however, should be no less than Medicaid.

- Copayments and deductibles: Employee cost-sharing should be similar to work-related insurance, which would exceed current Medicaid limits. For example, nominal copays on physician, emergency room and outpatient hospital visits and prescribed drugs might be elected by a state to help make the extension more affordable. A coinsurance of $100 for an episode of inpatient hospital care would be considered reasonable in some states, and would not unduly compromise the general need for first dollar coverage for persons eligible for this kind of plan.

- Eligibility limited by total income: The credibility of the program will be compromised if extremely high income persons are eligible. An upper limit not less than the poverty line, nor greater than double or triple the poverty line, would address this issue.

- Eligibility limited by reason for termination from public assistance: Similarly, if the purpose is to encourage employment, then eligibility should be limited to persons who leave assistance due to employment, not those who happen to have some earnings when they leave assistance for other reasons.

- Allowability of employee contributions: Provision should be made for employee contributions to the cost of premiums for the health insurance package (e.g., similar to Michigan's One-Third Share Plan). It would be useful to provide for a sliding premium which would vary over time (e.g., lower at first, increasing over time) or with ability to pay (increasing with income).

- Freedom of choice: States should have the latitude to limit freedom of choice to selected providers, just as employers are able to. For example, a state may wish to utilize HMOS, preferred providers, a managed care network or a specific private insurance plan, which would be different from options available under mainstream Medicaid.

## VII. Summary

A Medicaid extension with a different benefit structure than traditional Medicaid is uncharted ground. There is very little data on which to make assumptions of behavorial changes which will occur among recipients, providers, employers or state

Medicaid programs in response to the provisions of the new program.

For this reason, the strongest recommendation I would make is that states be provided with sufficient latitude so state policy makers can use their own ingenuity to craft solutions and programs uniquely appropriate to each state's own situation.

Actually, the strongest and most sensible recommendation I could make would be for the Congress to mandate what no state can do on its own -- universal minimum work-related health coverage. If we had universal minimum coverage, then we could be talking today of a Medicaid subsidy to employers who hire welfare recipients. There would be no "cliff" issue to deal with. Instead, we must deal with issues of fairness and equity, as some employees get a benefit others don't, and as some employers choose to participate and others do not.

Until we achieve some kind of universal coverage, a sensible modified Medicaid coverage is the best we can do to ease the transition from public assistance to work.

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[1] Annual Report, Robert Wood Johnson Foundation, 1982, page 13. [2] "MOST Employment Follow-Up Survey," Bureau of Employment Services, Michigan Department of Social Services, July 1986.

## STATEMENT OF ANDREW F. COBURN

Mr. **Coburn**. Good morning. I appreciate the opportunity to be here. I just barely have my voice back after a week of laryngitis, so I will try to be very brief.

I appreciate the opportunity to come and talk about our initiative in Maine to provide essentially an insurance pool for the uninsured. One very significant target population of that project will be the employed AFDC population who have gone to work, who have lost their benefits, and who do not have private insurance available to them in their employment settings.

I would like to share with you very briefly some of our experience with the problem of insurance coverage with the AFDC population and then briefly describe our initiative primarily as it differs a bit from the Michigan initiative, and then discuss in very summary fashion some of the thoughts that we have with regard to the Medicaid buy-in option, which is really the focus of this hearing today.

Our experience in Maine is not unlike the other States, so I won't belabor the data. Essentially 25 percent of our AFDC population is working. Sixty percent of those who become employed move into jobs that do not have health benefits. The Medicaid extensions, as in the other States and as other speakers have indicated, have not been terribly beneficial, for two reasons: many people are not eligible for them, and second, the problem of the "cliff" effect or "notch effect," that people get cut off.

The average wage in Maine for AFDC recipients going to work is $4.50 an hour. At that rate, certainly, purchasing private insurance, which in Maine currently costs somewhere in the vicinity of $100 a month, is not a realistic option. So the problem is a significant one, and what we are trying to do is create a State insurance pool in which we can bring not only former AFDC recipients who are employed but also the broader population of uninsured individuals and small businesses into an insurance program. These are demonstrations and will be demonstrated in two sites in the State.

The target groups are the near poor who are either unemployed or employed, and small businesses. We will be enrolling in the insurance pool AFDC recipients. Now, this is where we are going to be enrolling AFDC recipients in the same way that States are enrolling AFDC recipients in prepaid plans.

One of the key features of what we are trying to do is provide an opportunity for AFDC recipients to convert to our plan for the uninsured at the time at which they lose their Medicaid eligibility, either on extension or their full eligibility. That conversion privilege is one of the things that we see as a major incentive for encouraging enrollment in prepaid plans, which to date in Maine, anyway, has not been a major focus of our Medicaid initiatives.

But the question here this morning really is how could Federal policy be structured to support the kinds of initiatives that we have under way in Maine and that hopefully other States will be undertaking in the near future. Certainly I favor the approaches that Vern was suggesting with regard to giving States the flexibility to move away from the all-or-nothing Medicaid approach that we have had some difficulty with in dealing particularly with this population of employed AFDC recipients. The buy-in option, certainly from our standpoint, would be an extremely attractive alternative.

I think there are some questions with regard to eligibility, with regard to the nature of the insurance plans and with regard to cost sharing arrangements that we need to be concerned about. I will mention specifically the issue of premium cost sharing. I think that is from our standpoint a very important feature. We need to be able to allow the States to begin the process of asking recipients to assume some of the costs. The question becomes how much, and there need to be certain limits to that. We will talk about that, I presume, in the questions that will follow.

Certainly there is the question of plan requirements, what are the minimum plan requirements that we should be specifying in the legislation with regard to benefits, with regard to cost sharing features and with regard to incentive in delivery features designed to assure affordability for Medicaid programs. I think we do need to set some standards there.

One of the concerns that I have with the buy-in option is its potential complexity administratively. Are States going to take on something like this? Somehow we need to think about ways to make it simple enough for States to be enthusiastic about taking this on.

A final point is the linkage between the Medicaid buy-in option, and our existing employment training and employment support programs in the State. I think those programs in many respects could provide a bridge between the Medicaid programs, which typically have not been in the business of going out and brokering insurance coverage for Medicaid recipients, and employers to negotiate and work with individual clients in working through the administrative dynamics of actually implementing a buy-in program of the sort that has been envisioned by Congressman Ford.

Thank you.

[Testimony resumes on p. 91.]

[The prepared statement of Mr. Coburn follows:]

# TESTIMONY OF

## ANDREW F. COBURN

ACTING DIRECTOR, HUMAN SERVICES DEVELOPMENT INSTITUTE
ASSISTANT PROFESSOR, PUBLIC POLICY AND MANAGEMENT
UNIVERSITY OF SOUTHERN MAINE

Good Morning. My name is Andrew Coburn. I am the Acting Director of the Human Services Development Institute (HSDI) and an Assistant Professor of Public Policy and Management at the University of Southern Maine in Portland, Maine. Our Institute conducts policy research for, and provides technical assistance to, governmental and private agencies at the national and state level in the fields of health, child welfare, social services, aging and developmental disabilities. I and my colleagues are currently collaborating with the Maine Department of Human Services in the development of a state-subsidized, managed care insurance plan to extend insurance coverage to uninsured individuals and small businesses. One of the primary targets of this plan will be former AFDC recipients who are employed, have lost their Medicaid eligibility, and do not have private health insurance coverage.

I am here this morning to talk about Maine's efforts to fill the gap between Medicaid and private health insurance for those leaving welfare to go to work. I would specifically like to discuss:

1. Maine's experience with the problem of insurance coverage for former AFDC clients;
2. the state's demonstration activities to provide a state-subsidized insurance plan targeted to former AFDC recipients who have become employed; and
3. federal policy options for addressing the health insurance needs of the employed AFDC population.

## INSURANCE COVERAGE FOR FORMER AFDC RECIPIENTS

Approximately 30 percent of all Job Training Partnership Act (JTPA) Program clients in Maine are former AFDC recipients seeking to enter employment. The state also administers a Welfare Employment, Education and Training Program (WEET) to develop employment opportunities for welfare recipients and to provide the necessary supportive services to ensure successful placement. The WEET program is specifically designed to provide case management and other supportive services to help individuals establish the social and economic basis for continued employment and self-sufficiency.

Maine's job training programs have long recognized that the transition from welfare to employment is made substantially more difficult by the lack of health benefits in many of the jobs in which these individuals are placed. For those on AFDC, the prospects of losing Medicaid eligibility, even with the DEFRA extensions, represents a major hurdle to even considering leaving welfare. For those clients leaving AFDC for jobs without health benefits, the transition to employment can represent a substantial financial burden.

In Maine, approximately 5,000 or 25 percent of the state's AFDC caseload of 19,000 recipients are employed. An estimated 60 percent of all AFDC clients in the state's WEET Program who are placed in jobs do not receive health benefits in those jobs.[1] The extension of Medicaid eligibility for former

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[1] In a study of families dropped from the AFDC program because of the 1981 Omnibus Budget Reconciliation Act changes in the AFDC program, the GAO (1985) found that between 16 and 60 percent had no health insurance, depending on the site. In a similar study in Minnesota, Moscovice and Davidson (1986), found that 30 percent of those who had left AFDC because of the 1981 changes lacked health insurance coverage.

AFDC recipients does not appear to be addressing the needs of this uninsured population. In Maine, less than 2 percent of all employed AFDC clients are receiving the nine-month Medicaid extensions authorized under DEFRA. While a slightly larger percentage of employed recipients are receiving four-month extensions, the large majority of these individuals exhaust their Medicaid eligibility without transitioning into private sector health insurance coverage.

In Maine, several factors appear to contribute to the low participation in the Medicaid extensions. For those earning reasonable wages, the end of the 30 and 1/3 income disregard after four months puts them above the need standard used in determining eligibility for the nine-month extension. In the majority of cases, however, working AFDC individuals are employed in very low paying jobs and, therefore, continue to be eligible for cash assistance and Medicaid. Although anecdotal, there is also evidence that some clients who may be eligible for either the four-month or nine-month extensions are not aware of their eligibility for extended benefits and, therefore, do not receive them. In some cases, employment is not clearly indicated as the reason for leaving AFDC. In others, case workers fail to inform clients of the extended eligibility option.

One of the significant policy issues with regard to the availability of health insurance coverage for those leaving AFDC is the extent to which the absence of such coverage represents a disincentive for individuals to leave welfare and/or a barrier to continued employment. In perhaps the only empirical research on this issue, Moscovice and Davidson (1986, p. 17) estimate that women with health insurance had a significantly lower probability of being back on welfare one year later than women without private health insurance. The presence of poor health, in either the child or the mother, significantly increased the probability of re-entry into AFDC.

Although we do not have empirical data with which to address this issue in Maine, there is a clear consensus among human service and job training leaders that the absence of adequate health insurance coverage in the private sector represents a very significant barrier to successful employment and economic self-sufficiency for AFDC clients making the transition to work.

Despite potential disincentives created by the absence of adequate health insurance coverage, the evidence to date suggests that only a minority of those leaving AFDC to go to work actually return to AFDC and Medicaid because of the lack of health benefits. However, the burden of either purchasing insurance coverage or of not having insurance is very substantial for AFDC individuals and their children. With former AFDC recipients in Maine earning, on average, $4.50 an hour, virtually none are able to afford the cost of a private health insurance policy, which currently costs an estimated $100 per month in Maine.[2]

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[2] This is the premium cost only. It does not include co-insurance or deductible amounts or other out-of-pocket expenses typically associated with non-group policies.

In Maine, as in most states, the problem of providing health insurance coverage for employed AFDC recipients is strongly influenced by the broader problems of the uninsured and, more specifically, the growing crisis in the availability of health insurance among small employers. The probability of an AFDC recipient obtaining private health benefits upon entering the job market depends on the characteristics of the labor market. In Maine, over 90 percent of businesses are small (i.e., fewer than 15 employees); less than one-third of these firms offer health benefits. The chance of obtaining employer-based health insurance in a service dominated, small business economy such as we have in Maine is obviously very low.

## MAINE'S POLICY INTIATIVES TO EXPAND INSURANCE COVERAGE FOR AFDC RECIPIENTS

### Overview

In order to address the needs of Maine's growing population of uninsured individuals and businesses and those of AFDC recipients more specifically, the Maine Department of Human Services and the Human Services Development Institute at the University of Southern Maine are working with a broad coalition of businesses, labor, the state legislature, health care providers and human services groups throughout the state to develop and implement a state-subsidized, managed care insurance plan in two sites in the state. This plan is the centerpiece of a broader set of coordinated policy initiatives including an expansion of the state's Medically Needy program and the development of a high-risk insurance pool for uninsurable individuals.[3]

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[3] An expanded Project Description is available from the Human Services Development Institute.

The insurance plan will be targeted to two major groups: (1) the poor and the near poor who are not eligible for Medicaid, who are unemployed, or who are employed but not offered health benefits through their place of work and who cannot afford to purchase individual or group coverage themselves (this group includes former AFDC recipients who are now employed without health benefits); and (2) the AFDC Medicaid population in the two demonstration sites. Benefit coverage in the insurance plan will include both primary and acute care services.

AFDC Medicaid recipients will be encouraged to voluntarily enroll in the plan. Among the most important incentives for AFDC Medicaid recipients to enroll will be the opportunity which the plan provides for recipients to convert to the plan for the uninsured once they lose their Medicaid eligibility.

Open enrollment will be available year-round for non-Medicaid eligible individuals and families. A primary focus of both the Medicaid and non-Medicaid enrollment will be job training and placement programs. The new plan will develop coordinated enrollment drives with the state's WEET and JTPA centers to provide insurance coverage for those losing AFDC and Medicaid eligibility.

In order to recruit individuals and businesses into the plan and to insure the affordability of the plan, the state will subsidize premiums for certain low-income individuals and small, marginally-profitable firms. Subsidies will be established on a sliding scale based on the individual's or the business' ability to pay.

Maine's managed care insurance demonstration will be financed through a combination of state-appropriated funds, individual and business contributions to insurance premiums, and contributions by participating hospitals who provide free care to the plan out of bad debt/free care allocations which they receive under the state's hospital rate-setting program.

In order to insure the affordability of this plan, the plan will develop contractual, managed care arrangements with service providers including, at a minimum, strong case management, utilization review requirements and efficiency incentives.

## Extending Health Insurance to Employed AFDC Recipients

A key objective of Maine's insurance plan demonstration is to provide a mechanism for AFDC Medicaid recipients to obtain private insurance after cessation of Medicaid benefits. AFDC Medicaid recipients who voluntarily enroll in the managed care insurance plan will be given the option of converting to the plan for uninsured individuals once they become ineligible for the Medicaid program. This continuity of coverage will be available for all ex-Medicaid plan participants who do not have alternative health insurance coverage.

Consider the case of the AFDC recipient who, because of earned income becomes ineligible for Medicaid after exhausting her 4-month extension. Once her Medicaid benefits are terminated, she will become eligible for the plan for the uninsured (unless, of course, her employer offers health benefits). A partial or total subsidy will be available to cover her premium contribution. The amount of the subsidy will depend on her income. The plan will work with the employer to obtain a commitment toward the cost of the insurance premium. Through its one-on-one contacts with businesses whose employees seek to enroll in the plan and its broader marketing efforts, the plan will also seek to encourage businesses to extend coverage to all uncovered employees.

## FEDERAL POLICY CONSIDERATIONS: EXTENSION OR TRANSITION?

Current welfare reform proposals offer an important opportunity to address one of the significant problems or barriers undermining efforts to assist AFDC recipients to enter the work force and obtain longer-term economic self-sufficiency. Maine is responding to the challenge posed by these problems by including within its larger initiative to provide insurance coverage for uninsured individuals and businesses, special attention to the problems of former AFDC recipients. An important issue this morning is whether and how federal AFDC and Medicaid policy could be structured to support these initiatives and, indeed, provide incentives for states which have yet to address this problem, to undertake similar efforts.

It is my understanding that one of the proposals currently under consideration would extend Medicaid eligibility for AFDC recipients leaving welfare with earned income for nine months with a permanent income disregard. A second option would allow states to purchase private sector insurance coverage for individuals leaving AFDC. Although I will discuss both options, I will focus my remarks on the second option and, in particular, on some of the key policy issues which it raises. I will try to use our experience in Maine to suggest how such a proposal might be structured to complement state initiatives in this area.

## Medicaid Extension

The proposed 9 month extension of Medicaid eligibility would broaden short-term insurance coverage, primarily through the permanent extension of the income disregard. This option could be further strengthened by modifying current provisions related to the work and child care expense allowances. Indexing these allowances for increases in inflation (currently $75 per month for work-related expenses and up to $160 per child per month for child care expenses) would enable additional recipients who are just over the eligibility standard to maintain their eligibility for extended Medicaid benefits. The proposed changes in the language related to the basis for eligibility from "because of earnings" to "with earnings" would also significantly expand eligibility for the extension.

I see two problems with this proposal. First, our experience has shown that Medicaid extensions have little value in enabling recipients to secure long-term insurance coverage. Second, the extension option continues the all-or-nothing formula for Medicaid eligibility, limiting the states' ability to assist individuals and families who may not require total assistance. As such, the Medicaid extension option is likely to be more expensive than options which give states greater flexibility in establishing eligibility and cost-sharing requirements.

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Transition Option

Maine is currently one of a number of states which has targeted the employed AFDC population in dealing with the problems of the uninsured. The availability of broader federal support for purchasing health insurance for women leaving AFDC for employment would significantly enhance our efforts to achieve better and longer-lasting coverage for these individuals.

The proposal which has been suggested is very general; there are significant details regarding how such an option could or should be structured which remain to be specified. The following are among the key questions to be addressed:

1. Who would be eligible for any Medicaid transitional assistance program or benefit?
2. What minimum standards, if any, would be required of plans purchased on behalf of Medicaid recipients (e.g., benefits, cost-sharing features)?
3. What premium cost-sharing arrangements would be allowed?
4. How should the program or benefit be administered? What special arrangements may be required?
5. What relationship, if any, should the program have with existing job training and employment support programs targeted to this population?

The following are some brief comments on these issues based on our experience in Maine.

Eligibility: There are a host of potentially thorny issues here. For the sake of administrative simplicity, however, eligibility should probably be based on criteria similar to these proposed in the 9-month extension option. If states are allowed to require some premium cost-sharing with recipients (see below), recipients' out-of-pocket expenses could be treated as work-related expense for purposes of establishing AFDC/Medicaid eligibility. One of the problems here, of course, will be to protect states from having to absorb substantial cash assistance obligations. In addition, we have to be wary of the potential incentives that may be created for those who have left AFDC and who are now working without health benefits to return to welfare in order to become eligible for transitional insurance support.

Premium Cost Sharing: States will need considerably greater flexibility to develop innovative financing and service delivery approaches if they are to be able to move toward transitional programs of the sort suggested today. Although states currently have the option of enrolling Medicaid recipients into prepaid health plans, these options continue the all-or nothing pattern of Medicaid eligibility and financing. Specifically, in order to enable states and AFDC individuals to achieve the transition to private-sector coverage, states will need the flexibility to engage in premium cost-sharing arrangements with AFDC recipients and employers, and to negotiate specific benefit features. Our experience in Maine suggests that former AFDC recipients are both willing and able over time to contribute something toward the cost of health insurance. However, the state is currently constrained in asking individuals to do so.

As described earlier, we plan to enroll Medicaid recipients into our managed care insurance demonstration. Under this arrangement, the Medicaid program will pay a capitated amount for each Medicaid enrollee. Those enrollees who lose their AFDC and Medicaid eligibility (due to earned income or other reasons), will be able to join the plan for the uninsured. We anticipate that most will do so with some state subsidy offered to assist with the cost of the premium.

It would be highly desirable, in my view, if we and other states, could begin the process of transitioning recipients into private sector insurance before they loose their Medicaid eligibility, in other words, while they are receiving extended Medicaid benefits. The option of using Medicaid funds to purchase private plans (or to buy into their employer's existing plan) would facilitate our ability to do so.

Certainly one of the key issues that arises with regard to recipient cost-sharing is the amount of that obligation. Given the employment opportunities in most states for welfare clients, it is highly unrealistic to expect that recipients will be able to pick up a large share of the cost of the insurance premium. Limits on out-of-pocket expenses, including premium cost-sharing contributions, any co-insurance amounts, etc. are needed to protect recipients against unreasonable cost-sharing expectations.

Plan Requirements: One of the potential dangers in moving away from a full extension of Medicaid eligibility approach is, of course, that recipients might be bought into inferior plans with significant cost-sharing and inadequate benefits. In addition, most private insurance plans do not offer any significant cost-saving features and might, therefore, represent a significant expense in comparison with even traditional Medicaid benefits.

In the absence of a state plan such as we will have in Maine, states could be in the position under this proposal of brokering insurance plans for a significant segment of the AFDC/Medicaid population. Not only is this likely to be administratively very complex (discussed below), but it also suggests the need for some minimum standards for the types of plans that could be purchased. Some definition of a "qualified" plan (e.g., minimum benefit requirements) would have to be provided, in other words, to protect against recipients being brought into plans with inadequate benefits, excessive cost-sharing features and/or inadequate cost-containment features.

With the growing state experience in enrolling Medicaid recipients in prepaid plans, one option might be to limit state purchasing options to qualified prepaid plans. Although such an option might make the program easier to administer, particularly in states with substantial prepaid experience, we still need to be concerned with the quality of these plans to ensure a "good buy" for recipients and the Medicaid program.

Plan Administration: One of the significant drawbacks to any proposal giving states options for purchasing insurance is that they are likely to be complex and difficult to administer. Most state Medicaid programs are not prepared to become insurance brokers for their clients. Cost-sharing arrangements, while conceptually attractive, are difficult and costly to administer. Any more fully developed proposal must, therefore, attempt to achieve a compromise between the flexibility needed and desired and administrative complexity.

And finally, expanded Medicaid eligibility or publicly-subsidized purchasing of private insurance for former AFDC recipients should be conceived as part of the development of a comprehensive package of support services to assist recipients in making the transition to employment and self-sufficiency. Many states, including Maine, have developed sophisticated employment training support programs designed to assist former AFDC recipients. Policies expanding public and/or private health insurance coverage for former AFDC recipients should be coordinated with efforts to enhance existing programs to assure a more comprehensive package of supported employment services.

## SUMMARY

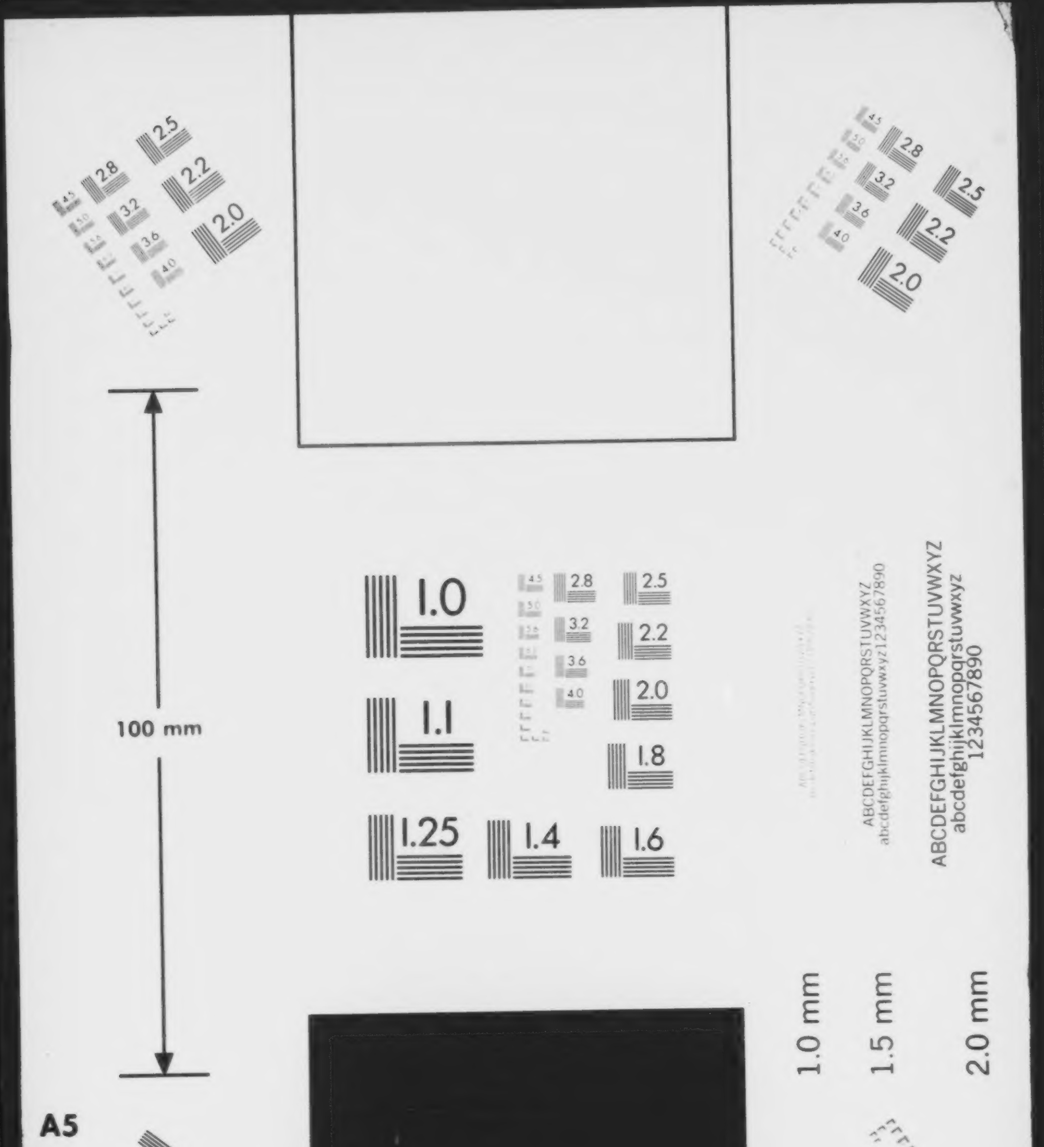
The problem of ensuring continued, long-term health insurance coverage for individuals and their families who are attempting to become economically self-sufficient is a significant one. The effectiveness of our current welfare employment and training programs is seriously compromised by the lack of health benefits offered in most of the jobs in which AFDC recipients are placed.

Maine has begun to address this problem with a state-funded initiative designed to allow AFDC Medicaid recipients to continue insurance coverage in the event they lose their Medicaid eligibility and do not have employer-based health benefits. The proposal to give states greater flexibility in using Medicaid to "transition" recipients into private sector coverage is appealing and would complement our state efforts nicely. I think it would also prove to be less expensive than the option of providing extended Medicaid benefits. It is less clear how such a plan could or should be structured to make it administratively feasible and to ensure appropriate protections for recipients and state Medicaid programs. Although challenging, the effort to develop more effective policies for enabling welfare recipients to achieve economic self-sufficiency is clearly worth it. We in Maine are prepared to assist you in that effort as you proceed with your deliberations on this important issue.

## References

General Accounting Office, An Evaluation of the 1981 AFDC Changes: Final Report. U.S. General Accounting Office, Washington, DC., July 2, 1985.

Moscovice, I. and Davidson, G. Health Care and Insurance Loss of Working AFDC Recipients. Center for Health Services Research, University of Minnesota, May, 1986.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Mr. **Waxman**. Thank you very much.

Just to address it head on and for the record, I would like to ask each of you, starting with Mr. Curtis, to respond to the proposal that Congressman Ford is suggesting, that as an alternative to the fixed 9-month transition in the bill, we allow former recipients to buy into Medicaid for a period of up to 3 years after a 6 to 9-month automatic extension.

Mr. Curtis.

Mr. **Curtis**. For the reasons we have talked about with respect to just delaying the notch effect rather than doing something in the longer run, I think that the suggestion is a good one. I would emphasize, though, that there should be the latitude to use that Title XIX financing subsidy to buy into the sorts of things that Vern Smith and Andy Coburn have described in Michigan and Maine as well.

I know you have a fixed dollar amount to deal with, and that dollar amount, I believe, was based upon the 9-month extension. He is suggesting if you can find other creative ways to extend it beyond that amount of time within that dollar level—is that the way it is going to work?—then you should do that. I would again suggest that you look at which populations are made eligible under those provisions. There may be populations that don't relate to the welfare reform agenda, at least as the States understand what that agenda is, and who have much more substantial incomes. It might, by focussing a bit on the people in greatest need that most directly relate to the welfare reform agenda, be possible to free the money for these longer-term transitions.

Mr. **Waxman**. Will you please pass the microphone over?

Ms. **Matula**. We certainly support the 9-month. We would hope it could even be longer, as we had recommended, 1 year. I had a mixed reaction myself to using Medicaid and allowing the former welfare recipient to buy into Medicaid. I think that is a good idea because I think our benefit package is excellent, but on the other hand, it kind of lets all those employers off the hook, and I don't like to see us go to that as our first option. It is not just the former cash assistance recipients that we should be looking at; we should be looking at all the uninsured who are working who won't have this opportunity to buy into Medicaid. If given the opportunity, the employers just walk away from it. That is the only thing that worries me about it.

Mr. **Curtis**. May I add something else? A related point is our current third party liability authority, as you know, says Medicaid is payer of last resort where a recipient has other coverage or is a dependent or spouse of someone with other coverage. What it doesn't do is give us the ability to say that where coverage is available, it has to be provided. With the lower income recipient—and you could say up to the poverty line, and I don't know what a reasonable level is—you could require us for the first 6 or 9 months to pay the employee's share of the premium. But what we need is an expanded third party coverage liability authority again to make sure that we take advantage of that available private sector coverage. We don't have that now.

Mr. **Waxman**. In other words, you want to tell the employee that if they have insurance at that job, they should take it rather than buy into Medicaid.

Mr. **Curtis**. It could be as a complement to buying into Medicaid. If we are going to extend Medicaid for everyone for 9 months, at least give us the ability to say if private coverage is available, you buy it, that will be the payer of first resort, and Medicaid would then cover the things not covered by that plan covered by Medicaid. But if we don't have the authority, we can't take advantage of that.

And again, the Syracuse University finding was that half of those who went off with earned income had private benefits without Medicaid, and in fact, their use of basic health services was comparable to Medicaid recipients. So apparently the difference in benefit coverage didn't have a significant effect on use of at least basic health services.

Mr. **Smith**. Let me take up where Barbara left off. Again, if I were to make one suggestion, it would be for a universal minimum employer-related health insurance. Then today we could be talking about a Medicaid subsidy for those employers who hired former public assistance recipients.

Stepping back from that, we should applaud Congressman Ford his for effort here. I would suggest just a couple things. One is that the transition coverage after the 6 to 9 months Medicaid would not necessarily need to be a full Medicaid package but could be something different from that, more akin to private insurance coverage; and second, that the employee contribution of a former public assistance recipient should be on some kind of a sliding scale. That is the way you can ease down the cliff as opposed to simply precipitously dropping off.

Mr. **Coburn**. I support the concept of giving States latitudes to buy into something other than just Medicaid. I think there are a number of opportunities, including the private employer's plan, that really ought to be looked at. I don't think we can expect Medicaid or should expect Medicaid to be the solution to the uninsured problem, and certainly something broader than just Medicaid ought to be included as part of any buy-in program.

Mr. **Waxman**. I appreciate your testimony and your answers to that question. I am sure we are going to be talking to you further as we look at the different options in welfare reform legislation.

Thank you for your participation.

That concludes the business before the subcommittee. We stand adjourned.

[Whereupon, at 11:36 a.m. the hearing was adjourned subject to the call of the Chair.]

# NURSING HOME REFORM

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TUESDAY, MAY 12, 1987

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:50 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. **Waxman**. The meeting of the subcommittee will please come to order. Today's hearing is on the bill, H.R. 2270, the Medicaid Nursing Home Quality Care Amendments of 1987.

This legislation was introduced last week by Chairman Dingell, myself and our first witness this morning, Congressman Claude Pepper. The purpose of this bill is to improve the quality of care that poor elderly and disabled Medicaid patients receive in nursing homes.

This year the Federal and State governments combined will pay an estimated $13.5 billion through the Medicaid program to roughly 14,000 nursing homes to provide care for about 1.3 million Medicaid patients. Medicaid pays over 40 percent of the Nation's nursing home costs, so what this program does about quality will have a major impact on all nursing home residents, whatever their source of payment.

This bill is 74 pages long. I will admit that our drafters are long winded, but the plain fact is that improving nursing home quality is a complex matter. The residents of nursing homes are among the most vulnerable in our society. Changing the rules under which nursing homes now operate means we have to proceed with care and with precision.

Some would argue that the Congress ought not proceed at all. I disagree. Hearings by both the House and Senate Aging Committees as well as the extensive work of the Institute of Medicine of the National Academy of Sciences, have demonstrated that there are significant numbers of nursing homes that are providing poor quality care. The current Federal/State monitoring system just isn't getting the job done.

Let me be clear that there are many nursing homes providing excellent quality care. They offer an essential service to our Nation's elderly and disabled citizens. But the time has come for the Medicaid program to stop paying for bad care, and with last year's Institute of Medicine report, we now have a framework through which to make the needed changes in an orderly way.

The message of this bill to poor quality homes is simple: shape up or the Federal Government will take its Medicaid beneficiaries and its Medicaid payments elsewhere.

Quality care is not budget neutral. It will cost money for homes to make the staffing and other changes necessary to improve the quality of care. It will cost money for the States and the Federal Government to improve their monitoring and enforcement activities.

The Congress is prepared to invest in nursing home quality. In April, the House passed a budget resolution that includes some new Medicaid spending for this purpose. While we do not have yet a final cost estimate on H.R. 2270, I believe the bill strikes a reasonable balance between the costs of improved quality and the constraints of the budget deficit.

H.R. 2270 was months in the making. Not only did we have the benefit of the Institute of Medicine study, but all of the organizations testifying today as well as many others contributed their expertise. Now we find ourselves in National Nursing Home Week beginning to legislate an improvement in nursing home quality.

I hope today's hearing will help us further strengthen this bill so that the Congress can at long last enact legislation to end poor quality care for elderly and disabled nursing home residents.

Before we recognize other members and our witnesses today, I would also ask unanimous consent to put the text of H.R. 2270 as well as a detailed summary of the bill in the hearing record. Without objection, that will be the order.

[Testimony resumes on p. 179.]

[The text of H.R. 2270 and detailed summary follow:]

100TH CONGRESS
1ST SESSION

# H. R. 2270

To amend title XIX of the Social Security Act to change the medicaid requirements for nursing facilities (other than intermediate care facilities for the mentally retarded) based on recommendations of the Institute of Medicine of the National Academy of Sciences.

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## IN THE HOUSE OF REPRESENTATIVES

MAY 5, 1987

Mr. DINGELL (for himself, Mr. WAXMAN, Mr. PEPPER, Mr. STARK, Mr. ROYBAL, Mr. SCHEUER, Mr. FLORIO, Mr. LELAND, Mr. RICHARDSON, and Mr. BRUCE) introduced the following bill; which was referred to the Committee on Energy and Commerce

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# A BILL

To amend title XIX of the Social Security Act to change the medicaid requirements for nursing facilities (other than intermediate care facilities for the mentally retarded) based on recommendations of the Institute of Medicine of the National Academy of Sciences.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicaid Nursing Home Quality Care Amendments of 1987".

(b) AMENDMENTS.—Whenever in this Act an amendment or repeal is made to a section or other provision, the reference shall be deemed to be made to that section or other provision in the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Section 1. Short title; amendments to Social Security Act; table of contents.
Sec. 2. Requirements for nursing facilities.
Sec. 3. Use of resident assessments.
Sec. 4. Survey and certification process.
Sec. 5. Enforcement process.
Sec. 6. Effective dates.

## SEC. 2. REQUIREMENTS FOR NURSING FACILITIES.

(a) APPLICATION OF SINGLE SET OF REQUIREMENTS FOR NURSING FACILITIES (OTHER THAN INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED).—Title XIX is amended by redesignating section 1921 as section 1922 and by inserting after section 1920 the following new section:

### "REQUIREMENTS FOR NURSING FACILITIES

"SEC. 1921. (a) NURSING FACILITY DEFINED.—In this title, the term 'nursing facility' means an institution (or a distinct part of an institution) which—

"(1) is primarily engaged in providing to residents (A) nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and

"(2) meets the requirements for a nursing facility described in subsections (b), (c), (d), and (e) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), (d), and (e).

"(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

"(1) QUALITY OF LIFE.—A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

"(2) SCOPE OF SERVICES UNDER PLAN OF CARE.—A nursing facility must provide services to maintain or improve each resident's mental and psychosocial well-being, as well as physical well-being, in accordance with a written plan of care which—

"(A) is initially prepared by the attending physician or other licensed health professional;

"(B) is periodically reviewed and revised by the attending physician or other licensed health professional after each assessment under paragraph (3); and

"(C) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met.

"(3) RESIDENTS' ASSESSMENT.—

"(A) REQUIREMENT.—A nursing facility must conduct a standardized, reproducible assessment of each resident's functional capacity through the use of an instrument which is specified by the State under subsection (h)(2) and which, upon completion, describes the resident's capability to perform daily life functions.

"(B) CERTIFICATION.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the accuracy of the assessment.

"(C) FREQUENCY.—Such an assessment must be conducted—

"(i) upon admission for each individual admitted on or after October 1, 1990;

"(ii) promptly after a significant change in the resident's physical or mental condition; and

"(iii) in no case less often than annually.

Such an assessment must be conducted, by not later than October 1, 1991, for each resident of the facility on that date.

"(4) PROVISION OF SERVICES AND ACTIVITIES.—

"(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

"(i) nursing services, physicians' services, and specialized rehabilitative services to meet the physical, mental, and psychosocial needs of each resident;

"(ii) medically-related social services to meet the physical, mental, and psychosocial needs of each resident;

"(iii) pharmaceutical services (including procedures for acquiring, dispensing, and administering all drugs and biologicals) to meet the needs of each resident;

"(iv) dietician services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

"(v) an on-going program of activities designed to meet the interests and the physical, mental, and psychosocial needs of each resident; and

"(vi) routine and emergency dental services (to the extent covered under the State plan) to meet the needs of each resident.

The services provided or arranged by the facility must be of adequate quality.

"(B) QUALIFIED PROVIDERS.—Services described in clauses (i), (ii), (iii), (iv), and (iv) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

"(C) REQUIRED NURSING CARE.—

"(i) IN GENERAL.—Except as provided in clause (ii), with respect to nursing facility services furnished on or after October 1, 1990, a nursing facility must provide 24-hour licensed nursing services which are sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least during the day tour of duty (of at least 8 hours a day) 7 days a week.

"(ii) Exception.—To the extent that clause (i) may be deemed to require that a nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary, upon the request of a State, may waive such requirement if the Secretary finds that—

"(I) the supply of nursing facility services in the area of the facility is not sufficient to meet the needs of individuals residing in the area and eligible for such services under the State plan,

"(II) the facility has at least one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

"(III) either the facility has only residents whose physicians have indicated (through physicians' orders or admission notes) that each such resident does not require the services of a registered nurse or a physician for a 48-hour period, or the facility has made arrangements for a registered professional nurse or a physician to spend such time at the facility as may be indicated as necessary by the physician to provide necessary nursing services on days when the regular full-time registered professional nurse is not on duty.

"(5) REQUIRED TRAINING OF NURSING SERVICE PERSONNEL.—A nursing facility must not use any individual, who is not a physician, registered professional nurse, licensed practical nurse, or licensed social worker, to provide nursing or nursing-related services to residents in the facility on or after January 1, 1990, unless the individual—

"(A) as a result of completing a training program which is recognized and approved by the State under subsection (f)(1), is competent to provide such services, or

"(B)(i) is enrolled in, and making timely progress in completing, such a training program, the completion of which reasonably assures that the individual is competent to provide such services, and (ii) with respect to providing specific nursing or nursing-related services, is competent to provide those services.

In addition, a nursing facility must have regular performance review and regular in-service training as assures that individuals used to provide nursing and nursing-related services to its residents are competent to provide those services.

"(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A nursing facility must—

"(A) require that the health care of every resident be provided under the supervision of a physician;

"(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

"(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

"(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

"(1) GENERAL RIGHTS.—

"(A) SPECIFIED RIGHTS.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(i) FREE CHOICE.—The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to participate, where appropriate, in planning care and treatment, and to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being.

"(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, or involuntary seclusion, and, subject to subparagraph (C), to be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

"(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, and written and telephonic communications.

"(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records.

"(v) LEAST RESTRICTIVE ENVIRONMENT.—The right to reside and receive services in the least restrictive environment, except where the health or safety of the individual or other residents would be endangered.

"(vi) Grievances.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances.

Clause (iii) shall not be construed as requiring the provision of a private room.

"(B) Notice of rights.—A nursing facility must provide written notice to each resident of the resident's rights under this title upon admission to the facility.

"(C) Use of psychotropic drugs.—Psychotropic drugs may be administered on the orders of a physician only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant in psychopharmacology reviews the appropriateness of the drug plan of each resident receiving such drugs.

"(D) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and be exercised by, the person appointed under State law to act on the resident's behalf.

"(2) TRANSFER AND DISCHARGE RIGHTS.—

"(A) IN GENERAL.—A nursing facility must permit each resident to remain in the facility and must not involuntarily transfer or discharge the resident from the facility unless—

"(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

"(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

"(iii) the safety of individuals in the facility is endangered;

"(iv) the health of individuals in the facility would otherwise be endangered;

"(v) the resident has failed to pay (or to have paid under this title on the resident's behalf) an allowable charge imposed by the facility; or

"(vi) the facility ceases to operate or participate in the program which reimburses for the resident's care.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (iv), in the case of a resident who becomes eligible for assistance under this title after admission to the facility, only charges which may be imposed under this title shall be considered to be allowable.

"(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

"(i) IN GENERAL.—Before effecting an involuntary transfer or discharge of a resident, a nursing facility must—

"(I) notify the resident (and an immediate relative of the resident, if known) of the transfer or discharge and the reasons therefor,

"(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

"(III) include in the notice the items described in clause (iii).

"(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

"(I) in a case described in clause (iii) or (iv) of subparagraph (A);

"(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge; or

"(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.

"(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

"(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (f)(2);

"(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

"(III) the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

"(IV) the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

"(C) ORIENTATION.—A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

"(D) NOTICE ON BED-HOLD POLICY AND READMISSION.—

"(i) NOTICE BEFORE TRANSFER.—Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident concerning—

"(I) the provisions of the State plan under this title regarding the period (if any) during which the resident will be permitted under the plan to return and resume residence in the facility, and

"(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

"(ii) NOTICE UPON TRANSFER.—At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident of the duration of any period described in clause (i).

"(iii) PERMITTING RESIDENT TO RETURN.—A nursing facility must establish and follow a written policy under which a resident—

"(I) who is eligible for medical assistance for nursing facility services under a State plan,

"(II) who is transferred from the facility for hospitalization or therapeutic leave, and

"(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the availability of a bed in a semi-private room in the facility.

"(3) ACCESS AND VISITATION RIGHTS.—A nursing facility must—

"(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

"(B) permit immediate access to a resident (subject only to reasonable restrictions) by relatives of the resident and others who are visiting with the consent of the resident; and

"(C) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident.

"(4) EQUAL ACCESS TO QUALITY CARE.—

"(A) IN GENERAL.—A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services for all individuals regardless of source of payment.

"(B) ADMISSIONS.—With respect to admissions practices, a nursing facility must—

"(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or title XVIII, and (II) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

"(ii) not require a third party guarantee of payment to the facility as a condition of admission to, or continued stay in, the facility; and

"(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this title, any gift, money, donation, or other consideration as a precondition of admitting the individual to the facility or as a requirement for the individual's continued stay in the facility.

"(C) CONSTRUCTION.—

"(i) Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

"(ii) Subparagraph (B) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the plan with respect to admissions practices of nursing facilities.

"(iii) Subparagraph (B)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

"(iv) Subparagraph (B)(iii) shall not be construed as prohibiting a nursing facility from charging, soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident).

"(5) PROTECTION OF RESIDENT FUNDS.—A nursing facility must—

"(A) upon written authorization by a resident, accept responsibility for holding, safeguarding, and accounting for the resident's personal funds, and providing each resident access to such funds and records of such funds, and

"(B) establish and maintain a system that—

"(i) assures a full and complete accounting of each resident's personal funds, and

"(ii) establishes a separate account for such funds in order to preclude any commingling of such funds with institutional funds or with the funds of any other person other than another such resident.

"(d) REQUIREMENTS RELATING TO PREADMISSION SCREENING FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS.—A nursing facility must not admit, on or after January 1, 1989, any new resident who—

"(1) is mentally ill (as defined in subsection (f)(4)(F)(i)) unless the State mental health authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental illness, or

"(2) is mentally retarded (as defined in subsection (f)(4)(F)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental retardation.

The facility must make a copy of any such determination part of the resident's clinical records.

"(e) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

"(1) ADMINISTRATION.—

"(A) IN GENERAL.—A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to maintain and improve the residents' physical, mental, and psychosocial well-being (consistent with any criteria the Secretary establishes under subsection (g)(4)).

"(B) REQUIRED NOTICES.—If a change occurs in—

"(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

"(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility, or "(iii) the individual who is the administrator of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of the new person or persons described in the respective clause.

"(C) NURSING FACILITY ADMINISTRATOR.—The administrator of a nursing facility must meet any standards established by the State under subsection (f)(3).

"(2) LICENSING AND LIFE SAFETY CODE.—

"(A) LICENSING.—A nursing facility must be licensed under applicable State and local law.

"(B) LIFE SAFETY CODE.—A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

"(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver will not adversely affect the health and safety of residents or personnel, and

"(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

"(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—A nursing facility must—

"(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

"(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

"(4) MISCELLANEOUS.—

"(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of sections 1124 and 1902(a)(13)(A)) and with all accepted professional standards and principles.

"(B) OTHER.—A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary, which may include any of the conditions described in section 1861(j)(15).

"(f) STATE PLAN REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—

"(1) SPECIFICATION OF NURSE TRAINING PROGRAMS.—Each State, as a condition of approval of its plan under this title, must specify, by not later than January 1, 1989, those training programs that the State recognizes and approves for purposes of subsection (b)(5) and that meet the minimum standards established under subsection (g)(2), but the failure of the Secretary to establish such standards shall not relieve any State of its responsibility under this paragraph. The State may not provide for the recognition and approval of a program—

"(A) offered by or in a nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), (d), or (e) within the previous 2 years, or

"(B) offered by a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

"(2) STATE APPEALS PROCESS FOR TRANSFERS.—As a condition of approval of a State plan under this title, effective for transfers from nursing facilities effected on or after October 1, 1989, the State must provide for a fair mechanism for hearing appeals on involuntary transfers of residents of such facilities. Such mechanism must meet any guidelines established by the Secretary under subsection (g)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

"(3) IMPLEMENTATION OF STANDARDS FOR NURSING FACILITY ADMINISTRATORS.—Effective January 1, 1990, as a condition of approval of a State plan under this title, the State is required to implement and enforce the standards (developed under subsection (g)(5)) respecting the qualification of nursing facility administrators.

"(4) STATE REQUIREMENTS FOR PRE-ADMISSION SCREENING AND RESIDENT REVIEW.—

"(A) PREADMISSION SCREENING.—As a condition of approval of a State plan under this title, effective January 1, 1989, the State must have in effect a preadmission screening program for making determinations (using any criteria developed under subsection (g)(6)) described in subsection (d) for mentally ill and mentally retarded individuals (as defined in subparagraph (F)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (g)(6) shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

"(B) STATE REQUIREMENT FOR ANNUAL RESIDENT REVIEW.—

"(i) FOR MENTALLY ILL RESIDENTS.—As a condition of approval of a State plan under this title, as of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (g)(6))—

"(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1905(h)) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

"(II) whether or not the resident requires active treatment for mental illness.

"(ii) FOR MENTALLY RETARDED RESIDENTS.—As a condition of approval of a State plan under this title, as of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (g)(6))—

"(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1905(d); and

"(II) whether or not the resident requires active treatment for mental retardation.

"(iii) FREQUENCY OF REVIEWS.—

"(I) ANNUAL.—Except as provided in subclauses (II) and (III), the reviews and determinations under clauses (i) and (ii) must be conducted with respect to each mentally ill or mentally retarded resident not less often than annually.

"(II) PREADMISSION REVIEW CASES.—In the case of a resident subject to a preadmission review under subsection (d), the review and determination under clause (i) or (ii) need not be done until the resident has resided in the nursing facility for 1 year.

"(III) Initial review.—The reviews and determinations under clauses (i) and (ii) must first be conducted (for each resident not subject to preadmission review under subsection (d)) by not later than April 1, 1990.

"(C) Response to preadmission screening and resident review.—As a condition of approval of a State plan, as of April 1, 1990, the State must meet the following requirements:

"(i) Residents requiring nursing facility services and active treatment.—In the case of a resident who is or was determined, under subsection (d) or subparagraph (B), both to require the level of services provided by a nursing facility and to require active treatment for mental illness or mental retardation the State must provide for (or arrange for the provision of) active treatment for such illness or retardation.

"(ii) Long-term residents not requiring nursing facility services, but requiring active treatment.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require active treatment for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must—

"(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

"(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

"(III) clarify the effect on eligibility for services under the plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

"(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such active treatment for the illness or retardation.

A State shall not be denied payment under this title for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

"(iii) OTHER RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING ACTIVE TREATMENT.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require active treatment for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must—

"(I) arrange for the safe and orderly discharge of the resident from the facility,

"(II) prepare and orient the resident for such discharge, and

"(III) provide for (or arrange for the provision of) such active treatment for the illness or retardation.

"(iv) RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES AND NOT REQUIRING ACTIVE TREATMENT.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require active treatment for mental illness or mental retardation, the State must—

"(I) arrange for the safe and orderly discharge of the resident from the facility, and

"(II) prepare and orient the resident for such discharge.

"(D) DENIAL OF PAYMENT WHERE FAILURE TO CONDUCT PREADMISSION SCREENING.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (d) or subparagraph (B) but for whom the determination is not made.

"(E) PERMITTING ALTERNATIVE DISPOSITION PLANS.—With respect to residents of a nursing facility who are mentally retarded and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require active treatment for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirement of this paragraph if, before October 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement.

"(F) DEFINITIONS.—In this paragraph and subsection (d):

"(i) An individual is considered to be 'mentally ill' if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition).

"(ii) An individual is considered to be 'mentally retarded' if the individual is mentally retarded or a person with a related condition (as described in section 1905(d)).

"(iii) The term 'active treatment' has the meaning given such term by the Secretary in regulations.

"(g) RESPONSIBILITIES OF SECRETARY RELATING TO NURSING FACILITY REQUIREMENTS.—

"(1) RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under plans approved under this title, and the enforcement of such requirements, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys.

"(2) ESTABLISHMENT OF MINIMUM NURSING PERSONNEL TRAINING STANDARDS.—For purposes of subsections (b)(5) and (f)(1), the Secretary shall establish, by July 1, 1988, minimum standards for training programs for nursing service personnel. Such standards may permit recognition of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section. Nothing in this paragraph shall be construed as preventing the Secretary from finding that an individual has met the requirement of subsection (a)(5) by completing a training program which is offered before, on, or after the date of the enactment of this section and which meets the minimum standards established under this paragraph.

"(3) FEDERAL GUIDELINES.—For purposes of subsections (c)(2)(B)(iii) and (f)(2), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards State appeals processes under subsection (f)(2) must meet to provide a fair mechanism for hearing appeals on involuntary transfers of residents from nursing facilities.

"(4) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (e)(1) with respect to—

"(A) its governing body and management,

"(B) agreements with hospitals regarding transfers of residents to and from the hospitals,

"(C) disaster preparedness,

"(D) direction of medical care by a physician,

"(E) laboratory and radiological services,

"(F) clinical records, and

"(G) resident and consumer participation.

"(5) STANDARDS FOR NURSING FACILITY ADMINISTRATORS.—For purposes of subsections (e)(1)(C) and (f)(3), the Secretary shall develop, by not later than January 1, 1989, standards to be applied in assuring the qualifications of administrators of nursing facilities.

"(6) FEDERAL MINIMUM CRITERIA FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (d) and (f)(4)(B) and shall notify the States of such criteria.

"(7) GUIDELINES, STANDARDS, AND CRITERIA NEED NOT BE ESTABLISHED BY REGULATION.— Unless otherwise specifically provided, whenever in this section the Secretary is required to establish guidelines, standards, or criteria the Secretary need not establish such guidelines, standards, or criteria by regulation.".

(b) INCORPORATING REQUIREMENTS INTO STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (13)(A), by inserting "which, in the case of nursing facilities, take into account the costs of complying with subsections (b), (c), and (e) of section 1921," after "State" the second place it appears; and

(2) by amending paragraph (28) to read as follows:

"(28) provide—

"(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (e) of section 1921 as they apply to such facilities;

"(B) for specifying in the plan (and making available upon request a description of) the items and services that are included in 'nursing facility services'; and

"(C) for compliance (by the date specified in the respective sections) with the requirements of—

"(i) section 1921(f) (relating to implementation of nursing facility requirements);

"(ii) section 1921(h)(2) (relating to specification of resident assessment instrument);

"(iii) section 1921(i) (relating to responsibility for survey and certification of nursing facilities); and

"(iv) sections 1921(j)(2)(B) and 1921(j)(2)(D) (relating to establishment and application of remedies);".

(c) FUNDING.—Section 1903(a)(2) (42 U.S.C. 1396b(a)(2)) is amended—

(1) by inserting "(A)" after "(2)", and

(2) by adding at the end the following new subparagraphs:

"(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing training programs described in section 1921(f)(1), regardless of whether the training programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the such training programs; plus

"(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1921(f)(4); plus".

(d) REVISION OF PREVIOUS DEFINITIONS.—Section 1905 (42 U.S.C. 1396d) is amended—

(1) by amending subsection (c) to read as follows:

"(c) For definition of the term 'nursing facility', see section 1921(a).";

(2) in subsection (d)—

(A) by striking "intermediate care facility services" and inserting "intermediate care facility for the mentally retarded",

(B) by striking "may include services in a public" and inserting "means an",

(C) in paragraph (3), by inserting "in the case of a public institution," after "(3)";

(3) in subsection (f), by striking "skilled" each place it appears; and

(4) by striking subsection (i).

(e) MAKING COVERAGE OF NURSING FACILITY SERVICES MANDATORY FOR ADULTS.—Section 1905(a)(4)(A) (42 U.S.C. 1396d(a)(4)(A)) is amended by striking "skilled".

(f) ELIMINATION OF PAYMENT DIFFERENTIAL.—Section 1903 (42 U.S.C. 1396b) is amended—

(1) by striking subsection (h), and

(2) in subsection (a)(1), by striking ", (h), and" and inserting "and".

(g) CLARIFYING TERMINOLOGY.—(1) Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

(A) in subparagraph (A)(ii)(VI), by striking "skilled" and by inserting "for the mentally retarded" after "intermediate care facility";

(B) in subparagraph (C)(iv), by striking "intermediate care facility services" and inserting "in an intermediate care facility"; and

(C) in subparagraph (D), by striking "skilled".

(2) Section 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is amended—

(A) in subparagraph (A), by striking ", skilled nursing facility, and intermediate care facility services" and inserting "services, nursing facility services, and services in an intermediate care facility for the mentally retarded",

(B) in subparagraph (A), by striking ", skilled nursing facility, and intermediate care facility and" and inserting "nursing facility, and intermediate care facility for the mentally retarded and";

(C) in subparagraph (C), by striking "skilled nursing facilities and intermediate care facilities" and inserting "nursing facilities"; and

(D) in subparagraph (D)—

(i) by striking "skilled nursing facility or intermediate care facility" and inserting "nursing facility", and

(ii) by striking "skilled nursing facility services or intermediate care facility services" and inserting "nursing facility services".

(3) Section 1902(a)(30)(B) (42 U.S.C. 1396a(a)(30)(B)) is amended by striking "skilled nursing facility, intermediate care facility," each place it appears and inserting "intermediate care facility for the mentally retarded,".

(4) Section 1902(e)(3)(B)(i) (42 U.S.C. 1396a(e)(3)(B)(i)) is amended by striking "skilled nursing facility, or intermediate care facility" and inserting "nursing facility, or intermediate care facility for the mentally retarded".

(5) Section 1902(e)(9) (42 U.S.C. 1396a(e)(9)) is amended—

(A) in subparagraph (A)(iii), by striking "skilled nursing facility, or intermediate care facility," and inserting "nursing facility, or intermediate care facility for the mentally retarded", and

(B) in subparagraph (B), by striking "skilled nursing facilities, or intermediate care facilities" and inserting "nursing facilities, or intermediate care facilities for the mentally retarded".

(6) Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(A) in paragraph (5), by striking "skilled",

(B) in paragraph (14), by striking ", skilled nursing facility services, and intermediate care facility services" and inserting "and nursing facility services", and

(C) in paragraph (15), by striking "intermediate care facility services (other than such services" and inserting "services in an intermediate care facility for the mentally retarded (other than".

(7) Section 1909 (42 U.S.C. 1396h) is amended—

(A) in subsection (c), by striking "skilled nursing facility, intermediate care facility" and inserting "nursing facility, intermediate care facility for the mentally retarded", and

(B) in subsection (d)(2)(A), by striking "skilled nursing facility, or intermediate care facility" and inserting "nursing facility, or intermediate care facility for the mentally retarded".

(8) Section 1911 (42 U.S.C. 1396j) is amended by striking ", intermediate care facility, or skilled nursing facility" each place it appears and inserting "or nursing facility".

(9) Section 1913 (42 U.S.C. 1396l) is amended—

(A) in the heading, by striking "SKILLED NURSING AND INTERMEDIATE CARE SERVICES" and inserting "NURSING FACILITY SERVICES";

(B) in subsection (a)—

(i) by striking "skilled nursing facility services and intermediate care facility services" and inserting "nursing facility services", and

(ii) by inserting before the period at the end the following: "and which, with respect to the provision of such services, meets the requirements of subsections (b) through (e) of section 1921";

(C) in subsection (b)(1)—

(i) by striking "skilled nursing or intermediate care facility services" and inserting "nursing facility services", and

(ii) by striking "skilled nursing and intermediate care facilities" and inserting "nursing facilities"; and

(D) in subsection (b)(3), by striking "skilled nursing or intermediate care facility services" and inserting "nursing facility services".

(10) Section 1915(c) (42 U.S.C. 1396n(c)) is amended—

(A) in paragraph (1), by striking "skilled nursing facility or intermediate care facility" and inserting "nursing facility or intermediate care facility for the mentally retarded";

(B) in paragraph (2)(B)(i), by striking ", skilled nursing facility, or intermediate care facility services" and inserting "services, nursing facility services, or services in an intermediate care facility for the mentally retarded";

(C) in paragraph (2)(B), by striking "need" and all that follows up to the semicolon and inserting "need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded";

(D) in paragraph (2)(C), by striking "or skilled nursing facility or intermediate care facility" and inserting ", nursing facility, or intermediate care facility for the mentally retarded";

(E) in paragraph (2)(C), by striking "or skilled nursing facility or intermediate care facility services" and inserting ", nursing facility services, or services in an intermediate care facility for the mentally retarded";

(F) in paragraph (5), by striking "skilled nursing facility or intermediate care facility" and inserting "nursing facility or intermediate care facility for the mentally retarded"; and

(G) in paragraph (7), by striking "or skilled nursing or intermediate care facilities" and inserting ", nursing facilities, or intermediate care facilities for the mentally retarded".

(11) Section 1916 (42 U.S.C. 1396m) is amended, in subsections (a)(2)(C) and (b)(2)(C), by striking "skilled nursing facility, intermediate care facility" and inserting "nursing facility, intermediate care facility for the mentally retarded".

(12) Section 1917 (42 U.S.C. 1396p) is amended—

(A) in subsections (a)(1)(B)(i) and (c)(2)(B)(i), by striking "skilled nursing facility, intermediate care facility" and inserting "nursing facility, intermediate care facility for the mentally retarded", and

(B) in subsection (c)(2)(B)(ii), by striking "skilled" each place it appears.

(h) DELAYED REPEAL OF REQUIREMENTS FOR PROGRAM TO LICENSE NURSING HOME ADMINISTRATORS.—(1) Section 1902(a) (42 U.S.C. 1396a(a)) is amended by striking paragraph (29).

(2) Section 1908 (42 U.S.C. 1396g) is repealed.

(3) The amendments paragraphs (1) and (2) shall not apply with respect to a State until the first date the State has implemented (under section 1921(f)(3) of the Social Security Act) the standards developed by the Secretary under section 1921(g)(5) of such Act.

(4) During the period after the date of the enactment of this Act and before the date described in paragraph (3) for a State, any individual in the State who meets the standards established by the Secretary under section 1921(g)(5) of the Social Security Act (relating to qualification of nursing facility administrators) shall be treated as meeting the requirements of section 1908 of such Act.

(i) UTILIZATION REVIEW.—Section 1903(i)(4) (42 U.S.C. 1396b(i)(4)) is amended by striking "or skilled nursing facility" each place it appears.

## SEC. 3. USE OF RESIDENT ASSESSMENTS.

(a) IN GENERAL.—Section 1921, as inserted by section 2, is amended by adding at the end the following new subsection:

"(h) RESIDENT ASSESSMENTS.—

"(1) DESIGNATION OF INSTRUMENT.—The Secretary shall designate, by not later than April 1, 1990, an instrument (or instruments) for use by a nursing facility in complying with the requirements of subsection (b)(3).

"(2) STATE SPECIFICATION OF INSTRUMENT.—Each State, as a condition of approval of its State plan and effective July 1, 1990, shall specify the instrument to be used by nursing facilities in the State in complying with the requirements of subsection (b)(3).

"(3) EVALUATION.—The Secretary shall evaluate, and report to Congress by not later than January 1, 1992, on the implementation of the resident assessment process under this subsection.

"(4) PENALTY FOR FALSIFICATION.—

"(A) An individual who willfully and knowingly certifies a material and false statement in a resident assessment described in subsection (b)(3) is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

"(B) An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment described in subsection (b)(3) is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

"(C) The Secretary shall provide for imposition of civil money penalties under this paragraph in a manner similar to that for the imposition of civil money penalties under section 1128A. Section 1128(c) shall not apply with respect to a civil money penalty imposed under subparagraph (A).".

## SEC. 4. SURVEY AND CERTIFICATION PROCESS.

(a) In General.—Section 1921, as inserted by section 2 and amended by section 3, is further amended by adding at the end the following new subsection:

"(i) Survey and Certification Process.—

"(1) State and federal responsibility.—Under each State plan under this title, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b) through (e). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

"(2) Surveys.—

"(A) Annual standard survey.—

"(i) IN GENERAL.—Each nursing facility shall be subject to an annual standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A. Section 1128(c) shall not apply with respect to a civil money penalty imposed under this clause. The Secretary shall review each State's procedures for scheduling and conduct of annual standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

"(ii) CONTENTS.—Each standard survey shall include—

"(I) an audit of a sample of the residents' assessments provided under subsection (b)(3) to determine the accuracy of such assessments, and

"(II) a survey of the quality of care furnished as measured by indicators of medical, nursing, and rehabilitative care, using a case-mix stratified sample of residents, and

"(III) a review of the facility's compliance with the requirements of subsections (b)(2), (b)(6), and (c)(1) (relating to scope of services, physician supervision and clinical records, and residents' rights) and of subsection (e)(1) (insofar as it relates to the standards described in subparagraphs (D) and (F) of subsection (g)(4)), relating to medical direction and clinical records.

"(iii) FREQUENCY.—

"(I) IN GENERAL.—Each nursing facility shall be subject to a standard survey not earlier than 9 months, and not later than 15 months, after the date of the previous standard survey under this subparagraph.

"(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) shall be conducted within 2 months of any change of ownership, administration, or management of a nursing facility, in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

"(B) EXTENDED AND FOLLOWUP SURVEYS.—Each nursing facility which is found, under a standard survey, to have provided poor quality of care shall be subject to an extended survey to identify policies and procedures which produced such quality and to determine whether the facility has complied with the requirements described in subsection (a). Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

"(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

"(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than April 1, 1990, and

"(ii) by individuals who meet such minimum qualifications as the Secretary establishes by not later than April 1, 1990.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

"(D) CONSISTENCY OF SURVEYS.—Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

"(E) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a surveyor under this subsection an individual who is serving (or has served within the previous 2 years) as a consultant to nursing facilities respecting compliance with the requirements of subsection (a).

"(F) TRAINING SURVEYORS IN USE OF ASSESSMENT INSTRUMENTS.—The Secretary shall provide for the training of State and Fedveyors in the use of the assessment instruments designated under subsection (h)(1).

"(3) VALIDATION SURVEYS.—

"(A) IN GENERAL.—The Secretary shall conduct sample onsite surveys of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsection (a), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's not meeting such requirements is binding and supercedes that of the State survey.

"(B) REDUCTION IN ADMINISTRATIVE COSTS FOR POOR PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State's survey and certification performance is not adequate, the Secretary shall provide for a reduction of the payment otherwise made to the State under section 1903(a)(2)(D) with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b) through (e). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1116 in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1116(a)(1).

"(C) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b) through (e), the Secretary may conduct a survey of the facility and, on that basis, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

"(4) INVESTIGATION OF COMPLAINTS AND MONITORING COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

"(A) investigate complaints of violations of requirements by nursing facilities, and

"(B) monitor, on-site, on a daily or other regular basis a nursing facility's compliance with the requirements of subsections (b) through (e) if—

"(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

"(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

"(iii) the State has reason to question the compliance of the facility with such requirements.

"(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

"(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

"(i) information respecting all surveys and certifications made respecting nursing facilities,

"(ii) copies of cost reports of such facilities filed under this title or under title XVIII,

"(iii) copies of statements of ownership under section 1124, and

"(iv) information supplied under section 1902(a)(38).

"(B) NOTICE TO OMBUDSMAN.— Each State shall notify the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) of the State's findings of noncompliance with any of the requirements of subsections (b) through (e), with respect to a nursing facility in the State.

"(C) NOTICE TO PHYSICIANS AND NURSING FACILITY ADMINISTRATOR LICENSING BOARD.— If a State finds that a nursing facility has provided poor quality of care, the State shall notify—

"(i) the attending physician of each resident with respect to which such finding is made, and

"(ii) the State board responsible for the licensing of the nursing facility administrator at the facility.

"(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.".

(b) INCREASING MATCHING PERCENTAGE FOR NURSING HOME SURVEY AND CERTIFICATION ACTIVITIES.—(1) Section 1903(a)(2) (42 U.S.C. 1396b(a)(2)), as amended by section 2(c) of this Act, is further amended by adding at the end the following new subparagraph:

"(D) for each calendar quarter during—

"(i) fiscal year 1990, an amount equal to 90 percent,

"(ii) fiscal year 1991, an amount equal to 85 percent,

"(iii) fiscal year 1992, an amount equal to 80 percent, and "(iv) fiscal year 1993 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1921(i); plus".

(2) Section 1903(b) (42 U.S.C. 1396b(b)) is amended by adding at the end the following new paragraph:

"(4) In making payments under subsection (a)(2)(D) for a calendar quarter beginning on or after October 1, 1992, the Secretary may limit the sums found to be necessary based on a percentage (not less than 100 percent) of the mean of the costs per bed, for all States, for nursing home survey and certification activities under this title.".

(3) Section 1903(r) (42 U.S.C. 1396b(r)) is amended by striking "paragraphs (2)" each place it appears and inserting "paragraphs (2)(A)".

(4) For purposes of section 1903(a) of the Social Security Act, proper expenses incurred by a State for medical review by independent professionals of the care provided to residents of nursing facilities who are entitled to medical assistance under title XIX of such Act shall be reimbursable as expenses necessary for the proper and efficient administration of the State plan under that title.

(c) REVISION OF PENALTY PROVISIONS.—(1) Section 1903(g) (42 U.S.C. 1396b(g)) is amended—

(A) in paragraph (1)—

(i) by striking "or intermediate care facility services" the first place it appears and inserting "or services in an intermediate care facility for the mentally retarded",

(ii) by striking ", skilled nursing facility services for 30 days,",

(iii) by striking ", skilled nursing facility services, or intermediate care facility services" and inserting "or services in an intermediate care facility for the mentally retarded",

(iv) by striking ", skilled nursing facilities, and intermediate care facilities" and inserting "and intermediate care facilities for the mentally retarded";

(B) in paragraph (4)(B), by striking ", skilled nursing facilities, and intermediate care facilities" and inserting "and intermediate care facilities for the mentally retarded";

(C) in paragraph (6)—

(i) by striking subparagraph (B),

(ii) in subparagraph (C), by striking "intermediate care facility services" and inserting "services in an intermediate care facility for the mentally retarded", and

(iii) by redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively; and

(D) by striking paragraph (7).

(2) Section 1902(a)(31) (42 U.S.C. 1396a(a)(31)) is amended—

(A) in the matter before subparagraph (A), by striking "skilled nursing facility services" and all that follows through "where" and inserting "services in an intermediate care facility for the mentally retarded (where", and

(B) in subparagraph (B), by striking "skilled nursing or intermediate care facility" and inserting "intermediate care facility for the mentally retarded".

(3) Section 1902(a)(33)(B) (42 U.S.C. 1396a(a)(33)(B)) is amended by inserting ", except as provided in section 1921(d)," after "(B) that".

(4) The amendments made by this subsection shall not apply to a State until such date (not earlier than October 1, 1990) as of which the Secretary determines that—

(A) the State has specified the resident assessment instrument under section 1921(h)(2) of the Social Security Act, and

(B) the State has begun conducting surveys under section 1921(i)(2) of such Act.

(d) MISCELLANEOUS CONFORMING AMENDMENTS.—(1) Section 1902(a)(44) (42 U.S.C. 1396a(a)(44)) is amended—

(A) in the matter before subparagraph (A), by striking "skilled nursing facility services, intermediate care facility services" and inserting "services in an intermediate care facility for the mentally retarded", and

(B) in subparagraph (A), by striking "that are intermediate care facility services in an institution for the mentally retarded" and inserting "that are services in an intermediate care facility for the mentally retarded".

(2) Section 1903(a)(7) (42 U.S.C. 1396b(a)(7)) is amended by inserting "subject to section 1921(i)(3)(B)," after "(7)".

(3) Section 1910 (42 U.S.C. 1396i) is amended—

(A) by striking "SKILLED NURSING FACILITIES AND" in the heading,

(B) by striking subsection (a), and

(C) by redesignating subsections (b) and (c) as subsections (a) and (b), respectively.

(4) Section 1866(c) (42 U.S.C. 1395cc(c)) is amended by striking paragraph (2) and by redesignating paragraph (3) as paragraph (2).

**SEC. 5. ENFORCEMENT PROCESS.**

(a) IN GENERAL.—Section 1921, as inserted by section 2 and amended by sections 3 and 4, is further amended by adding at the end the following new subsection:

"(j) ENFORCEMENT PROCESS.—

"(1) IN GENERAL.—If a State finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e) and further finds that the facility's deficiencies—

"(A) immediately jeopardize the health or safety of its residents, the State shall terminate immediately the facility's participation under the plan and may provide, in addition, for one or more of the remedies described in paragraph (2); or

"(B) do not immediately jeopardize the health or safety of its residents, the State may terminate the facility's participation under the plan and may provide, in addition, for one or more of the remedies described in paragraph (2).

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies.

"(2) SPECIFIED REMEDIES.—

"(A) LISTING.—Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

"(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

"(ii) A civil money penalty for each day in which the facility remains out of compliance with a requirement of subsection (b), (c), (d), or (e).

"(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

"(I) there is an orderly closure of the facility, or

"(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b) through (e).

"(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

"(B) Deadline and guidance.—(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations or otherwise by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

"(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

"(C) Funding.—The reasonable expenditures of a State to provide for temporary manage-

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ment and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan.

"(D) ASSURING COMPLIANCE.—If a nursing facility has not complied with any of the requirements of subsections (b) through (e) within 6 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date and for individuals who are in the facility who become eligible for medical assistance under the State plan after such date.

"(3) SECRETARIAL AUTHORITY.—

"(A) SECRETARIAL REVIEWS.—With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection. With respect to any other nursing facility in a State, the Secretary may, pursuant to subsection (i)(3) and except as provided in subparagraph (B), exercise the authority of the State under this subsection.

"(B) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—In exercising authority under subparagraph (A) in imposing a civil money penalty under paragraph (2)(A)(ii), the Secretary may not impose a civil money penalty that exceeds $10,000 for each day of noncompliance and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1128A.

"(C) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments under section 1903(a) with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), (d), or (e), over a period of not longer than 3 months, if—

"(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

"(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

"(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

"(4) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b) through (e).

"(5) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE STATE OR SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), (d), or (e) and finds that the failure immediately jeopardizes the health or safety of its residents, the facility's participation under the plan shall be immediately terminated and the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

"(6) SPECIAL RULES WHERE STATE AND SECRETARY DO NOT AGREE ON FINDING OF NONCOMPLIANCE.—

"(A) STATE FINDING OF NONCOMPLIANCE AND NO SECRETARIAL FINDING OF NONCOMPLIANCE.— If the Secretary finds that a nursing facility has met all the requirements of subsections (b) through (e), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

"(B) SECRETARIAL FINDING OF NONCOMPLIANCE AND NO STATE FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has not met all the requirements of subsections (b) through (e) and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

"(i) may impose any remedies (other than termination of participation) with respect to the facility, and

"(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(C).

"(7) SPECIAL RULES FOR TIMING OF TERMINATION OF PARTICIPATION WHERE REMEDIES OVERLAP.—

"(A) STATE AND SECRETARIAL FINDING OF NONCOMPLIANCE AND TERMINATION, BUT NO IMMEDIATE JEOPARDY, TIMING LEFT UP TO STATE.—If—

"(i) both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b) through (e),

"(ii) neither finds that the failure immediately jeopardizes the health or safety of its residents, and

"(iii) both find that the facility's participation under the plan should be terminated,

the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate.

"(B) STATE AND SECRETARIAL FINDING OF NONCOMPLIANCE, SECRETARIAL FINDING TO TERMINATE, BUT NO IMMEDIATE JEOPARDY, TEMPORARY DEFERRAL TO STATE.—If—

"(i) both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b) through (e),

"(ii) neither finds that the failure immediately jeopardizes the health or safety of its residents, and

"(iii) the Secretary, but not the State, finds that the facility's participation under the plan should be terminated,

the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(C).

"(C) STATE AND SECRETARIAL FINDING OF NONCOMPLIANCE, STATE FINDING TO TERMINATE, BUT NO IMMEDIATE JEOPARDY, TIMING UP TO STATE.—If—

"(i) both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b) through (e),

“(ii) neither finds that the failure immediately jeopardizes the health or safety of its residents, and

“(iii) the State, but not the Secretary, finds that the facility’s participation under the plan should be terminated,

the State’s decision to terminate, and timing of such termination, shall control.

“(8) STATE AND SECRETARIAL FINDING OF NONCOMPLIANCE, BUT NO IMMEDIATE JEOPARDY, IMPOSITION OF ALTERNATIVE OR ADDITIONAL REMEDIES.—

“(A) ONE PARTY FINDS ADDITIONAL REMEDY.—If—

“(i) both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b) through (e),

“(ii) neither finds that the failure immediately jeopardizes the health or safety of its residents, and

“(iii) the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the plan,

such additional or alternative remedies shall also be applied.

"(B) OVERLAPPING ADDITIONAL OR ALTERNATIVE REMEDIES.—If—

"(i) both the Secretary and the State find that a nursing facility has not met the requirements of subsections (b) through (e),

"(ii) neither finds that the failure immediately jeopardizes the health or safety of its residents, and

"(iii) both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the plan,

only the additional or alternative remedies of the Secretary shall apply.

"(9) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies. The remedies described in clauses (i), (iii), or (iv) of paragraph

(2)(A) may be imposed during the pendency of any hearing.

"(10) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XVIII.".

(b) CONFORMING AMENDMENT.—Section 1902 (42 U.S.C. 1396a) is amended by striking subsection (i).

### SEC. 6. EFFECTIVE DATES.

(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1921 of the Social Security Act, the amendments made by sections 2 and 4 (relating to nursing facility requirements and survey and certification requirements) shall apply to nursing facility services furnished on or after October 1, 1989; except that section 1902(a)(28)(B) of the Social Security Act (as amended by section 2(b) of this Act), relating to requiring State medical assistance plans to specify the services included in nursing facility services, shall apply to calendar quarters beginning more than 6 months after the date of the enactment of this Act.

(b) DESIGNATION OF RESIDENT ASSESSMENT INSTRUMENT AND ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1921 of the Social Security Act and except as provided in paragraph (2), the amendments made by sections 3 and 5 of this Act apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after the date of the enactment of this Act, without regard to whether regulations to implement such amendments are promulgated by such date.

(2) In applying the amendments made by section 5 for services furnished before October 1, 1989—

(A) any reference to a nursing facility is deemed a reference to a skilled nursing facility or intermediate care facility (other than an intermediate care facility for the mentally retarded), and

(B) with respect to such a skilled nursing facility or intermediate care facility, any reference to a requirement of subsection (b), (c), (d), or (e) is deemed a reference to the provisions of section 1861(j) or section 1905(c), respectively, of the Social Security Act.

(c) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this Act and implementing the amendments made by this Act.

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## Detailed Summary of H.R. 2270
## Medicaid Nursing Home Quality Care Amendments of 1987
(Dingell-Waxman-Pepper)
Introduced 5/5/87

### Overview

The purpose of the bill is to improve the quality of care available to Medicaid patients in nursing homes. It revises (1) the requirements for participation by nursing homes in Medicaid, (2) the process by which compliance with those requirements is monitored, and (3) the remedies available to Federal and State agencies in the event of noncompliance. The bill does not affect policies relating to the participation of nursing homes in the Medicare program. The bill also does not change current Medicaid policies relating to intermediate care facilities for the mentally retarded. The bill is a revision of H.R. 5450, introduced in the 99th Congress by Mr. Dingell and Mr. Waxman, which in turn was based on the report, Improving the Quality of Care in Nursing Homes, issued in 1986 by the Institute of Medicine of the National Academy of Sciences.

### Requirements for Nursing Facilities (Section 2)

The current law distinction between skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) would be eliminated, as would the current mandate for a reimbursement differential between SNF and ICF patients.

The bill defines nursing facilities as institutions primarily engaged in providing nursing care or rehabilitation services to residents. Effective October 1, 1989, except as otherwise noted, all nursing facilities participating in the Medicaid program would have to meet the following requirements relating to provision of services, residents' rights, preadmission screening and resident review, and administration. State reimbursement policies toward nursing facilities would have to take into account the costs of complying with these requirements, and States would have to specify the items and services covered by their payments to nursing facilities.

#### Requirements Relating to Provision of Services

(1) Quality of Life. The facility must promote maintenance or enhancement of the quality of life for each resident.

(2) Plan of Care. The facility must provide services in accordance with a written plan of care which describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met, and which is periodically revised after each resident assessment.

(3) Resident Assessment. The facility must conduct an assessment of each resident which describes the resident's capability to perform daily life functions. The assessment must be conducted on admission,

periodically thereafter (but at least annually), and promptly after a significant change in the resident's mental or physical condition. In conducting resident assessments, the facility must use an instrument developed by the Secretary or one developed by the State and approved by the Secretary. The assessment must be performed or coordinated (with appropriate participation of other health professionals) by a registered nurse who must certify its accuracy.

(4) Provision of Services and Activities. The facility provides, or arranges for the provision of, in accordance with each resident's written plan of care: (a) effective October 1, 1990, 24-hour licensed nursing services sufficient to meet the nursing needs of its residents (the facility need not provide round-the-clock services by registered professional nurses, but it must employ at least the services of a registered professional nurse on the day tour of duty 7 days a week; (b) physicians' services, and specialized rehabilitation services, (c) medically-related social services, (d) pharmaceutical services, (e) dietician services, (f) an on-going program of activities designed to meet the interests and physical, mental, and psychosocial needs of each resident, and (g) routine and emergency dental services, to the extent they are covered under the State's Medicaid program. The services provided or arranged to be provided by the facility must be of adequate quality and, with the exception of those described in (f), must be provided by qualified persons in accordance with each resident's written plan of care.

(5) Nurse Aide Training. Effective January 1, 1990, any unlicensed individual employed by a facility to provide nursing or nursing-related services to residents must either have completed, or be enrolled in, a training program approved by the State as meeting minimum requirements established by the Secretary of HHS. No nurse aide may provide nursing or nursing-related services to residents, whether during the course of training or after completion, if he or she is not competent to provide those particular services. The facility must provide regular performance review and regular in-service training for nurse aides.

(6) Physician Supervision and Clinical Records. The facility must ensure that all health care to residents is provided under the supervision of a physician, that a physician is available to furnish emergency care, and that clinical records are maintained for all residents which include the resident's plans of care and assessments.

### Requirements Relating to Residents' Rights

(1) Residents' Rights. The facility protects, promotes, and informs each resident of his/her rights (a) to choose a personal attending physician, to be fully informed in advance about care and treatment, and to participate, where appropriate, in planning care and treatment; (b) to be free from physical or mental abuse, corporal punishment, or involuntary seclusion, and from any physical or chemical restraints imposed for purposes of discipline or convenience; (c) to privacy with regard to accommodations, medical treatment, and written and telephonic communications; (f) to confidentiality of

personal and clinical records; (g) to reside and receive services in the least restrictive environment; and (h) to voice grievances concerning the care provided without reprisal. Administration of psychotropic drugs to any resident is subject to annual, independent, external review for appropriateness. In the case of residents adjudged incompetent, the rights of the patient shall be exercised by the person appointed under State law to act on the resident's behalf.

(2) Resident's Transfer Rights. The facility may only involuntarily transfer or discharge a resident if (a) transfer is necessary to meet the resident's welfare, as documented in advance by the resident's physician, (b) the resident no longer needs the level of services provided by the facility, as documented in advance by the resident's physician, (c) the safety of individuals in the institution is endangered by failure to transfer, (d) the health of individuals in the facility would otherwise be endanged, as documented in advance by a physician, (e) the resident has failed to pay (or have paid on his or her behalf by Medicaid or other payor) an allowable charge imposed by the institution, or (f) the facility ceases to operate or participate in Medicaid. The facility must notify residents and their families at least 30 days in advance of transfer, except when a resident's health improves sufficiently to allow a more immediate discharge or when a more immediate transfer is necessitated by the resident's urgent medical care needs, as recorded by the attending physician in advance of any transfer. The facility must notify the resident of (a) the reasons for the transfer, (b) the right to appeal to the State, and (c) how to contact the long-term care ombudsman and the protection and advocacy programs for the developmentally disabled and the mentally ill. The facility must provide sufficient preparation and orientation to those residents transferred to ensure safe and orderly discharge. In the case of a transfer for hospitalization or therapeutic leave, the facility must inform the resident of the State's Medicaid bed hold policy, if any, and the facility's own bed-hold policy, and of the resident's right to be readmitted immediately upon the availability of a semi-private bed in a case where the hospitalization or leave exceeds the State's or facility's bed hold policy.

(3) Access and Visitation Rights. The facility (a) permits immediate access to any resident by the resident's physician or a representative of the Secretary, the State, or the long-term care ombudsman; (b) permits immediate access, subject to reasonable restrictions, to relatives and others who are visiting with the resident's consent; and (c) permits reasonable access by any entity or individual that provides health, social, legal, or other services to a resident.

(4) Medicaid Discrimination. The facility establishes and maintains identical policies and practices regarding transfer, discharge, and Medicaid-covered services for all individuals regardless of source of payment. With respect to admissions, a facility does not (a) require individuals applying for admission, or residing in, the facility to waive their rights under Medicaid or Medicare, and informs those applying for admission regarding

application for Medicare or Medicaid benefits; (b) require a third-party guarantee of payment to the facility as a condition of admission or continued stay; or (c) charge, solicit, accept, or receive any payment (including gifts or donations) as a precondition for admitting an individual to the facility, or as a requirement for a continued stay in a facility. A State may establish more stringent prohibitions against admission discrimination vis-a-vis Medicaid patients.

(5) Protection of Resident Funds. The facility provides each resident access to his/her personal funds, assures a full and complete accounting of each resident's funds, and establishes a separate account for residents' funds.

### Requirements Relating to Preadmission Screening and Resident Review for Mentally Ill and Mentally Retarded Residents

(1) Effective January 1, 1989, nursing facilities may not admit any new resident who is mentally ill or mentally retarded unless the appropriate State agency has certified prior to admission that the individual's physical or mental condition requires the level of services provided by a nursing facility and, if so, whether the individual requires active treatment for mental illness or retardation.

### Requirements Relating to Administration and Other Matters

(1) Administration. The facility must be administered in a manner that enables it to maintain and improve residents' well-being, in accordance with criteria established by the Secretary of HHS. The facility must provide notice of any change in ownership, management, or administration to the State licensure agency. The facility's administrator must be licensed under State law; effective January 1, 1990, these State laws must meet minimum Federal criteria promulgated by the Secretary.

(2) Licensing and Life Safety Code. The facility must be licensed under applicable State and local law, and must meet Life Safety Code requirements made applicable by the Secretary.

(3) Sanitary and Infection Control and Physical Environment. The facility operates an infection control program and is built and maintained so as to protect the health and safety of residents, staff, and the public.

(4) Miscellaneous. The facility operates and provides services in compliance with all Federal, State, and local laws and with all accepted prosfessional standards. The facility meets such other requirements relating to the health and safety of residents or the facility's physical plant as the Secretary may find necessary.

## Responsibilities of the State Regarding Requirements for Nursing Facilities

In connection with the implementation of the above requirements relating to nursing facilities, States would be required under their Medicaid programs to carry out the following responsibilities:

(1) Specification of Nurse Aide Training Programs. The State must specify, by not later than January 1, 1989, the nurse aide training programs that the State approves as meeting the minimum requirements established by the Secretary of HHS. Training programs may be offered by nursing facilities to their employees, except in the case of facilities that have been determined out of compliance with Medicaid requirements during the previous two years. Where nursing facilities provide the training, the State must make the final determination as to whether an individual who has completed the training is competent to provide nursing and nursing-related services. Whether the training is provided in nursing facilities or elsewhere, the cost of the training is eligible for Federal matching payments at a uniform rate of 50 percent.

(2) Appeals Process for Transfers. Effective for transfers occurring on or after October 1, 1989, the State must provide a fair mechanism, consistent with guidelines established by the Secretary, for hearing appeals by residents of involuntary transfers.

(3) Nursing Facility Administrator Qualifications. Effective January 1, 1990, States must implement licensure standards for nursing facility administrators that meet the minimum criteria established by the Secretary.

(4) Preadmission Screening and Resident Review. Effective January 1, 1989, the State must have in place a preadmission screening program for the mentally ill and mentally retarded to determine the need for nursing facility care. State costs of preadmission screening would be matched by Federal funds at a rate of 75 percent. However, Federal Medicaid matching payments will not be available for the cost of nursing facility services to mentally ill or mentally retarded individuals not screened prior to admission after this date.

Effective April 1, 1990, the State, through the appropriate State agency, must have reviewed each mentally ill and mentally retarded resident of a nursing facility to determine (a) whether the individual requires the level of services provided by a nursing facility or whether the individual requires the level of services provided by another institution, and (b) whether the individual requires active treatment. These reviews must be conducted at least annually, using minimum criteria developed by the Secretary of HHS, and no Federal Medicaid matching payments would be available for patients for which timely reviews have not been conducted. State costs of conducting these resident reviews would be matched by the Federal government at a rate of 75 percent.

If a mentally ill or mentally retarded resident is determined by such review to require the level of services of a nursing facility and to require active treatment, the State must provide, or arrange for the provision of, active treatment at State expense. (The Secretary of HHS is responsible for defining active treatment in regulations). If a mentally ill or mentally retarded resident is determined not require the level of services provided by a nursing facility, but to require active treatment, the State must provide, or arrange for the provision of, active treatment at State expense. If such a resident has been living in a nursing facility for at least 2 1/2 years, the State must give the resident a choice of remaining in that facility or receiving services elsewhere; if the resident chooses to remain in that facility, Federal Medicaid matching funds will continue to be available for that resident's stay, even though the resident does not require the level of services in the nursing facility. If the resident has not been living in a nursing facility for at least 2 1/2 years, the State must arrange for the safe and orderly discharge of the resident from the facility, and must provide for, or arrange for the provision of, active treatment after discharge, at State expense. If a mentally ill or mentally retarded resident is determined not to require either the level of services provided by a nursing facility or active treatment, the State must arrange for the safe and orderly discharge of the resident from the facility.

### Responsibilities of the Secretary of Health and Human Services Regarding Requirements for Nursing Facilities

The Secretary has the responsibility to assure that the requirements for nursing facilities are implemented, monitored, and enforced so as to protect the health and safety of residents. In addition, the Secretary must develop the following guidelines, standards, and criteria in connection with the new nursing facility requirements. These need not be promulgated as regulations.

Minimum Nurse Aide Training Standards. The Secretary must, by July 1, 1988, establish minimum standards for State nurse aide training programs.

State Appeals Processes for Transfers. The Secretary must, by October 1, 1988, establish guidelines for fair mechanisms for hearing appeals on involuntary transfers of nursing facility residents.

Criteria for Nursing Facility Administration. By October 1, 1989, the Secretary must establish criteria with regard to (a) governing body and management, (b) agreements regarding transfers of residents to and from hospitals, (c) disaster preparedness, (d) medical direction, (e) laboratory and radiological services, (f) medical records, and (g) resident and consumer participation.

Nursing Facility Administrator Qualifications. By January 1, 1989, the Secretary must develop minimum standards to be applied by the States in licensing nursing facility administrators.

Criteria for Preadmission Screening and Resident Review. By October 1, 1988, the Secretary must establish minimum criteria for use by the States in conducting preadmission screening and resident review for mentally ill and mentally retarded individuals.

Resident Assessments (Section 3)

Designation of Instrument. No later than April 1, 1990, the Secretary must designate an instrument (or instruments) to be used by facilities in conducting resident assessments.

State Specification of Instrument. States must specify the instrument to be used by facilities within their jurisdiction by July 1, 1990; States may provide for the use of a different instrument than that developed by the Secretary if the alternate instrument is approved by the Secretary.

Penalties for Falsification. An individual who knowingly and willfully certifies a materially false assessment is subject to a civil money penalty of up to $1000 per assessment; an individual who knowingly and willfully causes another individual to certify a materially false assessment is subject to a civil money penalty of up to $5000 per assessment.

Survey and Certification (Section 4)

The bill repeals, effective October 1, 1990, the current law requirements (and associated penalties) for an annual "inspection of care" of each nursing home resident and for the periodic recertification of the need for care of each nursing home resident. (However, if implementation of the resident assessment process is delayed beyond October 1, 1990, the repeal of these existing utilization review requirements would be subject to a commensurate delay.) States could, at their option, continue to conduct annual "inspections of care" using skilled medical personnel with Federal Medicaid matching payments at the current law rate of 75 percent.

State and Federal Responsibilities. The States would be responsible for certifying the compliance of nursing facilities (other than those owned by the State) with the Medicaid participation requirements. The Secretary would be responsible for certifying the compliance of State-operated nursing facilities with these requirements. In general, certification would be based on the following two-step survey process, although any facility, at any time, would be subject, at the discretion of the State or the Secretary, to an unannounced extended survey.

Annual Standard Survey. Every nursing facility would be subject to an unannounced standard survey no more frequently than every 9 months and no less frequently than every 15 months. A standard survey must also be conducted within 2 months after any change in administration or management of a facility. The survey would include (1) an audit of a sample of resident assessments to determine their accuracy; (2) an assessment of the quality of care provided in the facility, as measured by "key indicators" of medical, nursing, and rehabilitation care, using a statistically valid, case-mix stratified sample of residents; and (3) a review of the facility's compliance with participation requirements regarding scope of services, physician supervision and clinical records, residents' rights, medical direction, and medical records. An individual who knowingly and willfully notifies, or causes to be notified, a nursing facility of the time or date on which such a survey is to be conducted is subject to a civil money penalty of up to $2000.

Extended Survey. Every nursing facility which, under a standard survey, is found to provide poor quality care, must undergo an extended survey which reviews the policies and procedures that resulted in poor patient quality outcomes and reviews the facility's compliance with each of the requirements for participation.

Survey Protocols and Personnel. The Secretary is required, by July 1, 1989, to develop and test a standard survey protocol and an extended survey protocol to be used by the States and the Secretary. The Secretary is also required to specify minimum requirements for State surveyors, and to provide for training of State and Federal surveyors in the use of resident assessments. States are required to measure and reduce inconsistency in the application of survey results among their surveyors. States may not use surveyors who have, within the previous 2 years, served as a consultant to a nursing facility.

Federal Validation Surveys. The Secretary is required to conduct sample onsite surveys of nursing facilities in each State, within two months of the State's surveys, in order to assess the adequacy of the State's surveys. The Secretary must use the same survey protocols used by the States.

Administrative Penalties for Inadequate State Survey Performance. Where the Secretary finds, on the basis of validation surveys, that a State's standard or extended survey procedures are not adequate, the State would be subject to a reduction in its Federal Medicaid matching payments for survey and certification activities of 33 percent of the ratio of the total number of residents in noncomplying surveyed facilities to the total number of residents in surveyed facilities. States would have a right to appeal any such penalties.

Investigation of Complaints and Monitoring Compliance. Each State must maintain procedures and adequate staff to (a) investigate complaints of violations and (b) monitor, on-site, on a daily or regular basis, a nursing facility's compliance with the participation requirements.

Disclosure. The Secretary and the States must make available to the public the results of all surveys conducted; copies of Medicaid or Medicare cost reports filed by nursing facilities; and copies of Medicaid and Medicare statements of ownership and significant business transactions. In addition, the States must notify nursing home ombudsmen of any adverse quality of care findings or other noncompliance found during the course of a survey. Where a State finds that a nursing facility has provided poor quality care, the State must notify the attending physician of each resident found to have received poor quality care and the State licensure board for the administrator at the facility involved. States must also provide access to all information available to its survey and certification agency to the State Medicaid fraud and abuse unit.

**Federal Matching Payments for State Survey and Certification.** Federal Medicaid matching funds would be available to States for the costs of nursing home survey and certification activities, including the costs of complaint investigation and monitors, at a rate of 90 percent in FY 1990, 85 percent in FY 1991, 80 percent in FY 1992, and 75 percent thereafter. As of FY 1993, the Secretary could limit the amounts paid to a percentage (but not less than 100 percent) of the mean of the costs per bed for all State for survey and certification activities.

### Enforcement (Section 5)

Effective October 1, 1989, the bill revises current law regarding enforcement of compliance with the requirements for participation as follows:

**General Framework.** If the State (or the Secretary) determines that a facility does not meet one or more of the requirements of participation, and that the deficiencies immediately jeopardize the health or safety of its residents, the State (or the Secretary) must immediately terminate the facility's participation in Medicaid, and may, in addition, provide for additional remedies. The facility would be entitled to a hearing, but only after termination occurred.

If the State (or the Secretary) determines that a facility does not meet one or more of the requirements of participation, but that the deficiencies do not immediately jeopardize the health or safety of its residents, the State (or the Secretary) may terminate the facility's participation, and may, in addition, provide for additional penalties or, instead of termination, may impose intermediate sanctions. Where the facility's deficiencies do not immediately jeopardize health or safety, termination could not occur until after the facility was given notice and the opportunity for a hearing; intermediate sanctions, however, could be imposed prior to a hearing. Termination of a facility's participation in Medicaid means denial of payment for existing Medicaid patients as well as any new Medicaid patients.

**Alternate State Remedies.** The Secretary is directed to promulgate minimum standards for intermediate sanctions for noncompliance by October 1, 1988. Whether or not the Secretary issues this guidance, States must, by October 1, 1989, have in place, whether by statute or regulation, the authority to impose, without prior hearing, the following remedies: (a) denial of payment for any individuals admitted (or converting to Medicaid from private pay status) after a specified date; (b) civil money penalties for each day during which the facility remains in noncompliance; (c) temporary receivership during the period a facility is being closed or during the period a facility is being brought into compliance; and (d) emergency authority to close the facility and/or transfer patients. State costs for exercising the temporary receivership or emergency closure remedies would be eligible for Federal Medicaid matching funds at a rate of 50 percent. The Secretary is authorized to waive these requirements if the State demonstrates that it has in place, by October 1, 1989, the authority to impose alternate sanctions that are as effective in deterring and remedying noncompliance as the remedies specified above.

Alternate Federal Remedies. In the case of noncompliance by a State nursing facility, or any other nursing facility, where the health and safety of residents is not immediately jeopardized, the Secretary may exercise any of the intermediate sanctions available to the State, described above. The Secretary may impose civil money penalties up to $10,000 for each day of noncompliance.

Rules for Overlapping State and Federal Remedies. In the case of noncompliance where a State and the Secretary have made different determinations with respect to compliance status or with regard to the remedies that should be imposed, the following general rules would apply:

(a) If either the State or the Secretary determines that a facility is not in compliance with the requirements for participation and that the deficiencies immediately jeopardize the health or safety of the residents, then the facility is immediately terminated.

(b) If the State determines that a facility is not in compliance with the requirements for participation and that the deficiencies do not immediately jeopardize the health or safety of the residents, then in general the State's selection and timing of remedies governs.

(c) If the Secretary determines that a facility is not in compliance with the requirements for participation and that the deficiencies do not immediately jeopardize the health or safety of the residents, and the Secretary believes that termination is appropriate, then the Secretary must allow the State 3 months to apply alternative sanctions and correct the deficiencies.

(d) If the Secretary has proposed remedies other than termination based on a determination that a facility is not in compliance with the requirements for participation and that the deficiencies do not immediately jeopardize the health or safety of the residents, and if the State has made no findings and proposed no remedies, then the Secretary's selection and timing of remedies governs.

Extended Noncompliance. In the case of any nursing facility that is not in compliance with any of the requirements of participation for a continuous period of more than 6 months, the State and the Secretary must, without prior hearing, deny payments for newly admitted residents (or existing residents converting to Medicaid from private pay status) until compliance is achieved.

Repeated Noncompliance. In the case of any nursing facility that is repeatedly out of compliance with any requirement of participation, the Secretary or the State may, after a hearing, terminate the facility's participation in Medicaid.

Mr. **Waxman**. I want to call on my colleagues who may wish to make opening statements at this time. Mr. Whittaker.

Mr. **Whittaker**. Mr. Chairman, I have no prepared opening statement but I would like to commend you and Chairman Dingell for initiating these hearings. I very much look forward to hearing the testimony.

Mr. **Waxman**. Thank you very much, Mr. Whittaker.

Mr. Wyden.

Mr. **Wyden**. Thank you, Mr. Chairman.

In this Congress, one of our top priorities has to be to develop a catastrophic health insurance protection program. To do the job right, we have to deal with the great catastrophe, which is the lack of long-term care services. It seems to me there are two parts to the long-term care equation.

One is ensuring quality of care and the other is giving everyone access to care. Your bill, Mr. Chairman, puts quality into the system, with standards for residents' rights and definitions of Medicaid coverage. Mr. Chairman, I think you have taken the first essential steps toward ensuring a better quality of life for the seniors of this country.

I think there are additional things we have to do. I would like to see us improve quality in the personal needs allowance. Medicaid beneficiaries receive $25 a month for personal items and expenses from the Medicaid program. That $25 has to pay for all noncovered items and services, such as laundry, clothing, tooth brushes, books, papers, hair cuts and even essential medical services such as glasses and hearing aids.

Mr. Chairman, I'm working on legislation now to increase the personal needs allowance by $10 a month to $35 a month. That money has been set aside in the House budget resolution this fiscal year and I'm looking forward to working with you, and our colleagues in the minority to get this legislation passed.

It seems to me that without those essentials, we really haven't afforded dignity and true quality health care services to older people in nursing homes.

There was a recent survey conducted in Northeast Ohio by the ombudsman program there and it found that if the personal needs allowance was raised, that extra money would be used for underwear, ice cream, clothing, new pillows and panty hose, hardly the kind of luxuries that seem to be extras. They are fundamental to ensuring quality of care, Mr. Chairman.

I look forward to working with you and our colleagues towards trying to beef up the personal allowance and improve quality at the same time.

Mr. **Waxman**. Thank you very much, Mr. Wyden.

Mr. Fields.

Mr. **Fields**. I have no opening statement, Mr. Chairman.

Mr. **Waxman**. Mr. Sikorski.

Mr. **Sikorski**. Thank you, Mr. Chairman.

I thank you for holding these hearings on nursing home reform. I also commend you and the Chairman of the Full Committee, Mr. Dingell, for introducing H.R. 2270, the Medicaid Nursing Home Quality Care Amendments of 1987, based on the Institute of Medicine's 1986 study.

The desire of all of us is for improvements in the rights and quality of life for nursing home residents, the working conditions of those who make their profession in the nursing home industry and the public and family responsibilities for the financing of quality long term care.

I developed some hands on knowledge of long-term care and the needs of the elderly when I worked as an orderly at the St. Francis Home for the Aged in Breckenridge, MN as I went through high school for 2½ years. I started at 75 cents an hour. That experience taught me a lot about life, professionalism, dedication, and hard work. It fostered a commitment to better long-term care and I ended up on the Governor's Council on Aging and the Minnesota Board on Aging.

As a State Senator, I served on the Health, Welfare and Corrections Committee for 6 years. I chaired the Finance Subcommittee during a period of time when dramatic cuts in programs for the elderly were being proposed. It was not an easy time but by working together, providers and advocates and legislators were able to ensure adequate funding for crucial services.

My experience in the State Senate in Minnesota taught me a great deal about the risks of creating long-term care health policy within the context of the budget process, an approach characteristic of this administration. It's one where you go into a room and without recorded votes, you close your eyes and hold your nose and make some votes to get the bottom line on some budget. Nursing home reform is an important step beyond such shortsightedness.

It will cost some money on the front end. Kirk Carson, who is the head of the Radison chains, an extremely successful business in Minnesota, said you get what you pay for. That's true in long-term care and health care policy generally.

In the longer term, this reform will lead to more efficient, effective care for the elderly and disabled—if we pay for it. The need for catastrophic care legislation has received much attention from the administration and in this Congress but the most catastrophic and prevalent expenses faced by the elderly are not acute but chronic; prescription drugs, nursing home care and home health care costs. Spending for preventive services is also largely ignored, even though such investments save money through improved health over the longer term.

Assuring that long-term care facilities provide the best possible services to the elderly and the disabled is an important step towards meeting our needs. We need to put an increasing quantity of money, real dollars, into long-term care and we need to be sure that those dollars are well spent.

I look forward to working with the Chairman and the members of the subcommittee towards that goal.

Mr. WAXMAN. Thank you very much, Mr. Sikorski.

As the members can notice, we have a very long list of witnesses we are going to hear today. Let me set the ground rules for this hearing. We are going to make all the prepared statements part of the record in full. We are going to have to be very strict in asking that each witness spend no more than 5 minutes in presenting oral testimony to the subcommittee. We will have to be equally strict in terms of the 5 minute rule for members to ask questions.

I think that is the only way we can be fair to everyone involved and make sure we can complete the schedule for today. We will probably be interrupted with House votes on the Floor as well.

The witnesses making up our first panel are family members of nursing home residents. Each has had to confront firsthand poor quality care in chronically deficient nursing homes. It is because of their stories and others like them that the Institute of Medicine report was issued and H.R. 2270 has been introduced.

I would ask that they now come forward and take seats at our table. We have Ms. Mary Fitzpatrick and Ms. Sue Mettel. Ms. Sue Mettel is from Naperville, IL, where she serves as president of the Oxford Land Family Council. Ms. Mary Fitzpatrick is from Madison, TN.

I want to thank both of you for taking off time from work and traveling so far to join in today's hearing. We appreciate your willingness to be here.

## STATEMENTS OF MARY FITZPATRICK, MADISON, TN; AND SUE METTEL, PRESIDENT, OXFORD LANE FAMILY COUNCIL

Ms. Fitzpatrick. Thank you for inviting me. I want to thank you for myself and all the patients that are in nursing homes.

My mother was 73 when she went to Belmont, and she had had Parkinson's, a congestive heart failure, and we could no longer care for her at home, and we were advised by the physicians at Vanderbilt that she needed care that we could not give her at home.

We took her to this Belmont because they had Vanderbilt doctors, and they had been attending her for years, and they had started a program there, and that was the reason that we chose Belmont.

We were only there like 2 days when my first problems occurred, and it was just a continuation. It just went downhill from there. She was there probably 6 or 8 weeks when she developed her first bed sores.

Then in February, they moved her to the skilled nursing unit. She was in the intermediate from October 12 until the last day of February, and then she was moved upstairs. And from then on, it was just downhill all the way.

She died on July 7, and I guess in June, I really didn't know who to go to. I didn't know about ombudsmen. And finally a nurse on the evening shift had told me about SAGA, which is Social Action Group on Aging, and she says, "If you could call them, they maybe can help you."

So I talked with them, and one of the ladies there said, "Go in and take pictures," and I hesitated on doing that. And finally it was so bad that a friend of mine, she says, "Well, let's see if we can't find out about who to go to," and she found out about Quality Assurance. So in June—I think it was like June 13—we called Quality Assurance, and I talked with a Mr. Saunders there and told him how bad the situation was, and he says, "Well, we'll go out and check on it." And I said, "How soon will it be? We need something done right away."

He says, "Probably within a week, a few short days." He says, "When we go, you won't know, nor will they know, when we're coming." And this went on for like 3 weeks. And then the week that she died, it did occur. And on Saturday, which was July 7, she passed away, and on Monday, Mr. Saunders called me and told me they had been there the previous week. They had found all these discrepancies, and that they were going in to close for admissions, and as they were talking to me, there was a team of doctors and nurses going in.

[Testimony resumes on p. 208.]

[The prepared statement of Ms. Fitzpatrick follows. The attachments referred to in the statement may be found in the subcommittee files:]

# Testimony of Mary Fitzpatrick
# before the
# Subcommittee on Health and Environment,
# House Commerce Committee
# Tuesday, May 12, 1987

I live at 900 Woods Lake Drive, Madison, Tennessee. I am an underwriting assistant in the Nashville office of a large insurance company, married with two adult children. I am the daughter of Maggie Conley, who died at Belmont Health Care Center, now known as Stratford Hall Health Care Center, in July 1984.

My mother was 75 years old at the time of her death. She had lived all of her adult life in Gallatin, Tennessee and had raised three children. Until disabled by a stroke at age 47, she had worked in a bag manufacturing plant. My father worked all of his life in a lumber yard.

My mother had suffered from Parkinson's disease and congestive heart failure for some time prior to her admission to the nursing home. She was living at home with my father who was then in his late 70's and with my brother, Kenneth McCullough. She had lost most of her speech but could still walk with the help of a walker, and our family was able to care for her at home. Our own care for her at home was supplemented by a visiting public health nurse and a physical therapist.

In September 1983, my mother's condition deteriorated suddenly over a period of about a week. She was admitted to Vanderbilt University Medical Center in Nashville for two weeks, and her neurologist and cardiologist told the family that she would require nursing home care upon discharge.

I and [illegible] looked at several nursing homes

I favored a facility close to my home in Madison, which is a Nashville suburb, but the facility did not want to take my mother because she was a Medicaid patient. A hospital social worker at Vanderbilt recommended Belmont Health Care Center, which was centrally located in relation to the homes and jobs of her children.

Mother had been going to Vanderbilt Hospital for years and a social worker told me that Vanderbilt doctors had started a program at Belmont and she would have a Vanderbilt doctor assigned to her. Belmont would be the only place the Vanderbilt physicians would be available.

When the family went looking for a nursing home, none of us had any prior experience and we did not know what to look for. We were shown the auditorium/chapel, the lunch room and one of the four floors with patient rooms. Based on what we saw, and on the recommendation of the hospital social worker, we decided to place our mother at Belmont and she was transferred there from the hospital on October 12, 1983. She was placed in an intermediate level bed.

When my mother was admitted to Belmont she had lost her ability to speak and was incontinent. However, she was still mentally alert and could respond with gestures to questions from her children. In fact, the therapist at Vanderbilt had made a poster with different squares that my mother could point to, to indicate what she wanted or needed, or her answer to a question.

The family did not want to put my mother into a nursing home, but the doctors said there was no choice. The night before my mother was discharged from the hospital she overheard them talking about a nursing home placement and somehow managed to speak for the first time in several months by getting out the single question, "Are you going to put me in that place?" I started crying but promised that I would visit her just as often as I would have at home.

A nurse's aide promised my mother that the nursing home would be just like a small hospital, and none of us knew any better.

The owner of the nursing home demanded a deposit from the family in order to take mother while we were waiting for Medicaid to approve her coverage. After Medicaid was approved, and paid for her care from the date of her admission, he still refused to refund our money. It was not until a year later, and after many complaints to state financial auditors, that he finally refunded what amounted to a double payment for services covered by Medicaid.

From the first day of her admission, my mother was visited on a regular basis by her three children. My brother changed shifts at work so that he could visit her on a regular basis in the afternoon. I went by directly from work and was there by 5:00 each afternoon during the week, missing dinner to stay until 8:30 or 9:00 p.m. When Mother began to lose weight my brother and I would eack stop to pick up soup at a nearby friend's house or a milkshake to take to her. My sister, Helen Dickerson, also came several nights a week and brought food, but her husband became terminally ill with cancer and she was not able to come on a daily basis.

On Saturdays my brother would go to the nursing home early in the morning, while I would wait until mid-morning so that I could go pick up my father to go see his wife. More or less the same schedule was followed on Sundays. My grown children would also go to visit their grandmother and would take their grandfather with them on occasion. On most Saturdays and Sundays, a family member was with Mother from about 9:00 or 10:00 in the morning until well after dinner. Whenever I or my brother were unable for some reason to come, we would notify each other and get friends to fill in for us. There was never a day during my mother's stay in the nursing home that she did not receive care and attention for several hours from family members or friends from outside the facility.

My mother had been in the facility for two days when the first problems appeared. I visited her and found that she was seated in her own wastes in a wheelchair. I went to ask for an aide's help in changing her, but the aide on the floor said she was too busy. I then went to the chapel, where I had found the staff usually congregated to sit around and talk. The staff, who were sitting there chatting with each other, said they were too busy. A couple of other patients said my mother had been moved after she had had the bowel movement and had been sitting in her own wastes for at least an hour and a half. I then went back and changed Mother's clothing and cleaned her up myself.

Problems immediately showed up with the food. When my mother first went into the facility she weighed about 180 pounds. By Christmas she was down to 120. Not only was the food unpalatable, but efforts were not made to feed her. She would eat for her children, and retained a good appetite. She became unable to feed herself and there were inadequate staff to take the time to sit and feed her. The facility refused to change her diet to include more of the foods that she willingly ate for us.

My daily routine quickly became one of cleaning up my mother's wastes, bathing her and changing her linens as soon as I arrived each afternoon. Not only would the facility not provide such basic care, but I had to fight for supplies to be able to provide that care myself. I came in the Wednesday before Thanksgiving and was unable to find any clean linens for Mother, who had been lying in her wastes for some time. I was told by the staff that there was a new policy that allowed each patient only two sets of linens. I demanded to speak personally to the facility's owner. He confirmed that that was the policy and justified it on the basis that he was not making enough money from Medicaid. I became angry and raised so much sand that he finally relented and allowed me to have fresh linens for Mother that afternoon. However, there was always a shortage of clean linens and other supplies. Keeping Mother clean, even when the family was providing the labor, was a constant battle. A family friend, who also visited several days a week, brought surplus washcloths that her husband was able to get through his job. Many days a search would have to be made of linen closets on several floors in order to find a single set of clean bedsheets.

Of course, most of the other patients in the 210-bed facility lacked the family support that my mother had, and they simply lay in their own wastes indefinitely.

The first bedsores appeared after my mother had been at Belmont for about six weeks. The first couple of sores showed up on her back close to her tailbone. Neither of the sores ever went away. By the time of her death eight months later one of the original sores measured about three inches across and one and a half inches deep.

New sores continually developed, and the ones that she had got worse. It got to the point where there was no way that she could lie that she would not be lying on a bedsore. The staff simply never complied with the instructions about turning her regularly, and she was physically unable to turn herself. The family would of course turn her while we were there, but she was supposed to have been turned every two hours. One of her worst sores was on an ankle that had been badly injured when a staff member had lowered a bed rail on it. When the family came in the day the injury occurred and found what had happened, I asked three separate members of the nursing staff to write up the incident, but it never found its way into Mother's medical chart.

As with the constant battles over obtaining linen, the family faced a constant struggle keeping Mother stocked with needed medical supplies. We brought from home a couple of sheepskins, and they disappeared the second day Mother was at Belmont. Next to go were a necklace given to her by my brother, and then her earrings. Most of her Christmas presents had disappeared within the first week after the holidays. The family was constantly having to supply new gowns to replace the ones' that disappeared. The family bought a wheelchair for Mother, but it, too, kept disappearing from her room, and we would have to go searching for it all over the facility.

A roommate even suffered the indignity of having her potty chair and bedpan stolen. In order to pad the growing number of bedsores and chafed places all over my mother's body, the family kept bringing pillows, but they too would disappear.

Not only would the staff not turn my mother as required, or bathe her bedsores and keep them free from waste, but the family had to dress the sores themselves. Because there was so little staff, two sympathetic nurses taught me how to clean the bedsores and gave me the name of a medical supply company where I could get special dressings. I bought and used these dressings on a regular basis. The nursing home administration kept offering the alibi that they couldn't find out whether the pharmacy carried these dressings. I was later told by the pharmacist that such dressings were routinely supplied to Belmont's skilled nursing wards, but that the administration was unwilling to spend the money for the dressings for the intermediate level patients.

Dehydration was also a problem. For patients like my mother who were unable to reach out for water, they could go for many hours without anything to drink, because staff would not come around to give them water. My mother's roommate told us of one incident in which Mother had dabbed a Kleenex in spilled water on a tray and held it in her mouth to relieve her thirst.

In late February, I came to the facility and found my mother in what was apparently a state of shock. There was never any explanation of what had happened, but one of her legs was almost entirely black and blue from the knee down. We were told that Mother would probably not survive the night, but she did. Thereafter she was moved to a skilled bed, where she remained until her death in July. The reason for moving her, it was said, was that she was refusing to eat and needed to be tube fed.

The stench in the skilled unit was even worse that on the intermediate floors, because now added to the smell of human wastes was the smell of rotting flesh. My mother's bedsores had a terrible odor about them. One of her roommates had a foot with gangrene which was ultimately amputated. [An aide later testified that during this same period another patient, who was a cancer victim, developed a nest of maggots in a bedsore on his foot, which was subsequently amputated. - See newspaper article, attached.]

The tube feeding process was unattended by staff in the same way that other nursing functions were neglected. The tube goes through the patient's nose down to the stomach. A pump pushes the food through the tube. The bags would go empty, but no one would come around to close them off so the patients would lie there with the tubes down their throats and the pump motors running. My brother and I would turn off Mother's tube feeder and do the same for the other patients in her room. One evening we decided to wait to see just how long it would take after the feeders were emptied before staff would come in to tend to them. We waited an hour and a half.

One night after Mother had been moved to this skilled nursing bed in a room in which everyone was being tube-fed, I arrived to find that one of the other women in the room who was being tube-fed had vomited all over herself and was lying in her own vomit. I took a towel and wiped off her face and reported the situation to staff. When I left two and a half hours later, no one had ever come to tend to the woman.

The following night, when I arrived, the same woman was again covered with her own vomit. I again looked for staff to help but could find no one who would acknowledge any responsibility for her. I finally pressured one aide into helping me when I started cleaning her up myself.

One of the things that bothers me the most is that I know that my mother was aware of what was going on, even though she could not express herself other than through gestures and facial expressions, until shortly before her death.

We started looking for somewhere we could move my mother to after she had been at Belmont about a month and it was clear that the problems were not going to be addressed. However, by that time she had a staph infection, and no other facility would take her. After that, she just continued to get worse and worse, so there was never any possibility of persuading another facility to accept her, although we tried.

There was never any infection control to speak of during the months that my mother was in the intermediate care unit and suyffered from a staph infection. Each day when I changed her linens and bedclothes, I would stick them in a plastic bag if I could find one, but often just left them on the floor in her room. It was only after she was moved to the skilled unit that I noticed nurses handling her infected bedclothing with plastic gloves and disposing separately of the soiled linens so that they would not contaminate other patients

None of the family or friends who were caring for my mother knew where to turn for help. We had never heard of the nursing home ombudsman program and were never given any notice of its existence or the existence of state or federal agencies that regulate nursing homes. Finally, in June, 1984, after my mother had been in Belmont for nine months, a friend who was helping to care for her said that surely there must be somebody in state government who would do something about this situation. She spent some time calling around and finally got the name of someone on the Tennessee Department of Health and Environment's nursing home inspection staff. I called him and explained that the family was really worried about retaliation. I said that before I could talk to him I had to be sure that the complaint could not be linked back to my mother if the nursing home tried to make trouble for whoever was responsible for an investigation. He promised that confidentiality would be protected. We spent about 45 minutes on the phone and he said that they would get right out and investigate the situation within the next few days.

I waited and waited but nothing happened. A few days after my complaint the other three women in mother's room were all moved out of her room for different reasons within the space of 24 hours, leaving her alone for about ten days.

One of my complaints to the state had been that I wanted Mother's bedsores taken care of. At the nursing home I was told that a physician would have to order that.

The state inspector came on Tuesday, July 3, but I didn't know it.

On Thursday afternoon, July 5, when I came in, I could see from the doorway that Mother's sheets were all soaked with blood. She was lying on her side crying. I pulled back the covers and found that her bedsores had been debrided right there in the nursing home. Her blood-soaked bandages had not been changed. I asked the nurse in charge for the floor to please change the bandages. She first refused to do it, saying they had been packed. I told her I was not asking her to change the packing, I just wanted Mother to be cleaned up. Finally she did that.

I could not imagine, given the seriousness of her bedsores, that they would have done such a thing without taking her to the hospital. Debridement is cutting away of dead tissue in bedsores so that good tissue can come back. Debridement is not necessarily a procedure that requires hospitalization but due to the depth of Mother's bedsores, and so many of them, I was shocked that the doctor had done hers at the nursing home, and even more so when we turned her and I realized he had done both hips. She couldn't lie on her back so she had to lie on one side or the other. She must have been in agony. I asked what they could do for the pain and the nurse said, "Tylenol is all we can give."

I stayed with Mother until 11:00 that night and we lifted her and turned her every two hours. Between turnings my brother and I went looking for a hospice or someplace we could take her to. I wanted to get her a waterbed and just take her home. She was in such bad shape that I went to the nurse in charge and also the aide for her room and asked them to please relay the message that the bedsores had been debrided and when they turned Mother to please make sure they didn't drag her, to pick her up. It would take two people.

When I came back the next morning at 7:00 a.m. she was in exactly the same position as I had left her the night before. There was an aide attending to another patient, and I said, "Well, I just will be damned." The aide said, "What is the problem?" I said, "She has not been turned. She is lying in exactly the same position as I left her last night, pillows the same and everything."

I think Mother probably went into shock, but in any event she died the following day, July 7, 1984.

When I was getting ready to go to the funeral home, I received a call at home from the state inspector. He said he was calling to let me know that they had just been out a few days ago to investigate the allegations I had made three weeks earlier, and that I would be pleased to know that they had found that most of my complaints were substantiated. I told him that it was too late, and that Mother was dead.

The undertaker said that he had never seen a body in such bad condition, and he had to enclose the lower half of her body in a plastic bag.

Just a few days before my mother's death and nearly three weeks after my complaint to the state agency with no action having been taken, a sympathetic nurse at the facility gave me the name of a volunteer organization in Nashville that I had never heard of, called SAGA, which stands for Social Action Group on Aging. She told me not to let her employer know where I had gotten the name. I called SAGA's number and explained what had happened, and the apparent failure of the state to de anything. It was suggested that I take a picture of mother's bedsores, and perhaps they could be used to persuade somebody to take some action. I did so, and the photos which I brought with me today were taken a few days before Mother's death.

I am convinced that the state called Belmont before they went out to investigate my complaint. It was later admitted by the state commissioner of health and environment that it had been the practice of many inspectors to routinely call nursing homes to warn them that an inspection was about to occur, and to tell them of the specific complaints. I do know that the pledge of confidentiality was broken, and that the written report at the complaint investigation, which was given to Belmont had my name and my mother's name clearly legible. I have brought a copy of the complaint investigation report with me.

I went to a hearing in August that was to decide whether Belmont's admissions should be reopened. No one told us, when the owner's attorney was making statements about what a good nursing home Belmont was, and that they weren't guilty of all these charges, that I could have made a statement. After the hearing was over we found out.

Since my mother's death, I have tried to work with other people in Tennessee who have been pushing for better nursing home care. I found that although Belmont was one of the worst facilities in the state, there were others that were just as bad. I have compared my experiences with other family members and they all have much the same stories to share. The kinds of problems that have continued over the years at Belmont or Stratford Hall can be found in nursing homes throughout Tennessee.

I and SAGA and several other family members from Belmont brought suit in state court to try to force the nursing home to clean up its operation. Several of the other plaintiffs, who had loved ones still in the home, were afraid of retaliation and asked to bring the suit in the name of John Doe or Jane Doe. They were denied this permission and have been afraid to press the lawsuit as a result. The court said that the lawsuit could not be used as a class action to help other people who are not willing to come forward and use their own names. At this point, I am convinced that, at least under the laws in Tennessee, there is no way for private individuals to try to use the courts to protect their loved ones' rights in a nursing home.

I was working for a large insurance company at the time that Mother was in Belmont, and found that the company was actually the underwriter for Belmont. I said that surely a place like that was a bad risk. One of the company's marketing executives said that, on the contrary, nursing homes were a great moneymaker for insurance companies. He said that if people were hurt, they could never really do anything about it, and that the only real exposure was workmen's compensation claims related to staff back injuries from lifting patients. I see now that he was right.

Nothing has changed at Belmont since my mother died, other than the name, which was changed to Stratford Hall to avoid the bad publicity that had been associated with the old name. The investigation of my complaint led to a suspension of admissions, but no real improvement occurred. Three weeks ago Stratford Hall's admissions were suspended for the fourth time in three years. I have brought along a copy of the order [attached] suspending the admissions, and you can compare it to the complaint investigation involving my mother [also attached]. You will see that the same things are going on there now, and that other people's mothers are going through the same Hell that my mother went through.

I really think the problem comes back to greed on the part of the owner. He would not spend money for enough staff or supplies or food or anything else.

Yet the flow of taxpayers' money to this nursing home has continued without interruption. Since 1983, Belmont has received $842,000 on Medicare payments and $6.1 million in Medicaid, for a total of nearly $7 million from these two sources alone.

Not all of the staff were lazy or unkind. In fact, some of them were very kind, but they did not last. The indifference and the lack of concern from the ownership went throughout the organization, and it affected most of the staff eventually.

Now there is talk of the state and the federal government closing down Stratford Hall or taking away its Medicaid certification, which would be practically the same, because so many of its residents are on Medicaid. Where would those people go? We tried desperately to move my mother, but there was no place for her to go. People are waiting in line to get into nursing homes in Tennessee, and that is why suspension of admissions doesn't work. Tennessee has not had civil monetary penalties, and there has been no way to speak to the owner of a place like Belmont in the only terms he understands or cares about, which is to affect his own profits.

I don't know if Tennessee will ever enforce nursing home standards as it should, just because the conflicts of interests among the people that control the enforcement process. At the same time that my mother was dying at Belmont, a patient in a nursing home in Kingsport, Tennessee was also being eaten up with bedsores. The bedsores in his face were infested with maggots and his family complained to state inspectors, but the majority leader of our state Senate owned an interest in the facility. No enforcement action was taken until the patient had died and a Nashville TV station had run a series on the terrible conditions there.

Nursing homes in Tennessee are regulated by the Board for Licensing Health Care Facilities. Thirteen of the fifteen members are representatives of regulated health care industries. There are no consumer members. Last year a state coalition of senior citizens groups tried to get a consumer member added to the board. Our legislature refused to do so, but added a third nursing home administrator to the two nursing home industry representatives already on the Board. This board decides what rules will govern nursing homes in Tennessee, which facilities shall have their admissions suspended, and which shall have their licenses revoked. Two of the three nursing home members were appointed to their positions on the board even though they had operated facilities which had had their admissions suspended. This board's record of enforcement is just what you would expect from foxes guarding a henhouse.

The people in nursing homes and their families are afraid and unable to do anything to help themselves. If you don't do something for them, nothing will ever change.

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THE TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT

**IN THE MATTER OF:**

**STRATFORD HALL**
**(formerly, Belmont Health Care Center)**
**1400 Eighteenth Avenue South**
**Nashville, Tennessee 37212**

**(Nursing Home License No. 6960)**

BY ORDER OF THE
COMMISSIONER

## SUSPENSION OF ADMISSIONS

In exercise of my authority and duty under Tennessee Code Annotated, Section 68-11-207(b), I now find the conditions in this 210-bed, licensed nursing home to be detrimental to the health, safety or welfare of its patients.

This conclusion is based upon the findings of Department inspectors on March 26-27, April 3, April 6, and April 13, 1987. The following deficiencies are detrimental to the health, safety or welfare of the patients:

1. Very simple and basic requirements of patient care were not met, as shown by the following examples:

   a. At 11:00 a.m., 32 of 56 patient beds were wet with urine and some beds had circles, showing that they had been wet for some time. At 6 p.m., 8 other patient beds were checked and all were wet with urine. At 6 p.m. on another day, 29 of 104 patients were wet with urine that did not seem to be recent. A resident complained of always being left wet all night. Similar findings had been cited as deficiencies in October, 1986 and November, 1984.

   b. A patient bed pan was found on a bedside table with a large amount of bowel movement, but it required 20 minutes and a request from surveyors to remove it. When surveyors showed a full bedside commode to a facility nurse, the nurse contended that there were no means to clean and disinfect bed pans and commodes. Two (2) urinals had a heavy build-up of surface dirt and stains. Two (2) other commode chairs were full of urine. At least 4 patient rooms had a very strong odor of urine. Similar deficiencies were cited in October, 1986.

   c. A patient was observed walking down a hall with wet pajamas, urinating on the floor while he ate cigarette butts. He walked past clean, but uncovered, linens.

d. A female patient had dried stool on her face, in her hair, on her hands, on the bedrails, and across her covers. A male patient was found playing with his stool, which he had thrown on the floor and smeared on himself.

e. At least 3 patients had no covers and one, who had only a wet sheet, complained that she had been asking for a blanket throughout the night. On another day of the inspection, 4 patients were wet with urine and had no covers.

f. A patient had been awakened at 5:00 a.m. to prepare for a dialysis treatment. At 6:00 a.m., surveyors found him in the cafeteria, asleep with his face laying in French toast and syrup. Surveyors asked a nursing home official to assist him, but, two (2) hours later, he remained in the same position, although 2 other patients were then trying to help him.

g. Several patients needed grooming (such as shaves, nail care, hair and oral care), but the nursing home lacked toothpaste and had only 4 combs available. Pillows in 10 rooms were torn, cracked, stained or dirty, and no replacements were available, although this same deficiency had been cited in October, 1986.

h. By 11:30 a.m., 6 of 12 patients who needed baths had yet to receive them. By 11 a.m., 50 of 167 patients had yet to receive their scheduled morning care. Similar deficiencies had been cited in October, 1986 and November, 1984.

i. Surveyors found a patient sitting in a sling in a whirlpool bath, but no attendant was present to protect the patient from scalding or from slipping out of the device into the water.

j. Although the same deficiency had been cited in October, 1985 and November, 1984, 4 of 5 restraints checked were not released every 2 hours and residents were left sitting in chairs without benefit of exercise or bathroom privileges.

k. Although cited in October, 1986 and April, 1985, 31 of 103 call lights were not accessible to patients because strings were broken or missing, were too short for the resident to reach, did not activate when the cords were pulled, or lighted signals in a different location than the area in which the signal had been activated. In a check on one floor at 6:20 p.m., neither telephones, nor call lights, were answered by the nursing home's staff. Thus, residents could not summon assistance when needed.

l. Although cited in October, 1986, April, 1985 and November, 1984, at least 3 patients were not given privacy when doors were left open during treatment. Another patient stood in a patient lounge, barefoot and in a hospital gown that exposed his buttocks to other patients who were eating. Surveyors noted that he was eating from another patient's tray and called the incident to the attention of the nursing home's staff, who replied that they would get him another tray and left him sitting exposed in the dining area.

m. In one area of the nursing home, 6 patients needed some assistance with eating, but only one patient got this help. Snacks, scheduled for 10 a.m., had not been distributed by 11 a.m. and were found uneaten on bedside tables at 2 p.m. Of 56 trays observed, 18 were served late. Patients complained of cold food, which was confirmed by thermometer readings. Sixty-two (62) of 126 trays had substantial waste with patients eating only a small portion of their meal. Two (2) diets were reversed and a diabetic received a pureed diet with ice cream, while a patient on a pureed diet received the diabetic's tray:

2. Fundamental nursing practices were deficient and patient needs for skilled nursing care were neglected, as shown by the following examples;

   a. Although formally cited as a deficiency in October, 1986, April, 1985 and November, 1984, 17 of 51 patients observed had poor body positioning without supportive devices needed for proper body alignment, to prevent decubitus ulcers, to prevent deformities, and to avoid contractures. According to the nursing home's records, the number of patients with decubitus ulcers increased from 8 on March 26 to 13 on April 6.

   b. As cited in April, 1985 and November, 1984, catheter care was inadequate. Three (3) of 6 urinary catheters had heavy sediment without evidence of increased fluids, periodic evaluation, follow-up, or documentation that physician orders had been followed.

c. Three (3) of 10 patient records did not contain monthly weights, although one (1) record documented a weight measured on a day when the facility's records indicated that the patient was hospitalized. Similar deficiencies were cited in 1984 and 1985.

d. Medications, which physicians had ordered to be administered at 9:00 a.m., were still being given at 11:05 a.m. A medication error rate of 8.9% was calculated. Licensed personnel failed to wash their hands when preparing and administering medications. On another day, the medication administration record showed that 19 medications and treatments were not done on a floor of the nursing home that had 56 patients. Medications missed included Theodur, Nitrostat, Nitro Ointment, Persantine, Reglan, and Vistaril. Treatments omitted included extensions of the knee, application of Lidex cream, Mycologcream, and Chemstix. Personnel records showed that the licensed practical nurse on duty was simultaneously working on two (2) other floors with sole responsibility for the nursing care of 132 patients.

e. Deficiencies in infection control techniques were found for the fourth consecutive year. Drainage and secretion precautions were not taken when ordered by a physician in one (1) case or when obvious in a second case with a draining infection. As had been cited in the three (3) previous years, nursing personnel neglected to wash their hands after direct patient care and before moving to another patient. One (1) resident's dressing was 8 or 9 days old and had stuck to the wound, causing a total debridgement of the wound when it was finally removed.

3. Although this nursing home may have met the minimum personnel ratios required by regulation, nursing personnel were either unprepared or unable to meet the total nursing care needs of its patients. This conclusion is supported by the above observations, as well as the following points;

a. The performance observed by surveyors indicates a lack of on-going in-service training on problem areas in the facility, insufficient staff development, poor communications between departments within the home, inadequate supervision of nursing care, a failure of supervisory personnel to conduct an on-going evaluation of daily patient needs, and a lack of rehabilitative nursing.

b. In early April, the facility had approximately 182 patients, although they were unsure of their exact census. Of these, 24-25 were skilled nursing patients on the third floor and approximately 144 patients required "total nursing care" (e.g. 8 of 29 first-floor patients required substantial assistance; of 56 patients on the second floor, 26 were incontinent and 8 required assistance to eat; 13 of 50 patients on the third floor had decubiti; and 35 of 47 fourth-floor patients were incontinent). The nursing home maintained the following staff to serve these patients:

| Floor | 1 | 2 | 3 | 4 | Total |
|---|---|---|---|---|---|
| April 3rd/Day Shift | | | | | |
| Patients | 29 | 56 | 50 | 47 | 182 |
| Nursing Assistants | 1 | 4 | 5 | 5 | 15 |
| Licensed Nurses | 0.5 | 2 | 2 | 0.5 | 5 |
| April 6th/Day Shift | | | | | |
| Patients | 29 | 56 | 47 | 47 | 179 |
| Nursing Assistants | 1 | 4 | 5 | 3 | 13 |
| Licensed Nurses | 1 | 0 | 2 | 1 | 4 |
| April 6th/Evening Shift | | | | | |
| Patients | 29 | 56 | 48 | 47 | 180 |
| Nursing Assistants | 1 | 2 | 3 | 2 | 8 |
| Licensed Nurses | 0.33 | 0.33 | 1 | 0.33 | 2 |

Particular concerns are the single aide available to the 29 patients on the first floor, the absence of any licensed personnel on the floor while staff take meals, the reduction in coverage whenever personnel must leave their assigned floor to obtain supplies or to respond to an emergency, a single nurse being assigned to more than one floor, the lack of a Registered Nurse on the day shift in the skilled nursing unit, the aides beginning a second shift when other personnel did not report, the accummulation of 450 hours of overtime work during the last pay period, and the lack of supervision by a Registered Nurse during the 3 to 11 p.m. shift.

c. Further, interviews with employees indicated that they were not familiar with the needs of the patients, perhaps due to their short tenure and the lack of training. One of the nurses had been there less than a week and new aides were assigned to as many as 10 patients on their first day on the job, before receiving any training. The in-service training coordinator, who has worked there 5 months, did not know how many patients were in the home, who was on duty, or which workers had been trained. At 8:10 a.m., personnel, who had reported at 7:00 a.m., had yet to find the key to the medication cart for the skilled nursing unit, an example of the problems throughout the facility.

It is, therefore, ORDERED, that this licensed nursing home shall not admit any new patients or residents until such time that further orders may be issued. This suspension shall continue until I am shown that these conditions have been corrected and will continue to remain corrected, as is required by Tennessee Code Annotated, Section 68-11-207(b).

This nursing home was advised of many of these problems on March 27th, but had not eliminated the detriments to patients' health, safety or welfare by April 13th. Given the lengthy disciplinary history of this facility under its current ownership, its repetition within 6 months of 8 violations of the federal requirements to participate in the Medicare and Medicaid programs, and its repetition of the same deficiencies for 4 consecutive years, this Department has no expectation as to when, or if, this suspension of admissions may be removed.

A hearing into this matter will be conducted before the Board for Licensing Health Care Facilities on Wednesday, June 24, 1987 at 9:00 a.m. at 287 Plus Park Boulevard, Nashville. Before the hearing, additional charges will be filed upon docket number 17.17-D-87-0270A. Upon the nursing home's written request, a more prompt hearing may be held before an administrative judge or before the Board for Licensing Health Care Facilities, should they elect to meet in special session. Upon hearing the matter, the Board or administrative judge may continue, revoke or modify the suspension of admissions; revoke, suspend or condition the license of the nursing home; and enter such other orders as deemed necessary, all as provided by Tennessee Code Annotated, Sections 68-11-207(b), 68-11-208, and 4-5-301 et seq.

I further find that the deficiencies in this nursing home threaten serious bodily harm to the patients or residents of the facility. As is required by Tennessee Code Annotated, Section 68-11-221, I will appoint one or more special monitors to be present in the facility for at least twenty (20) hours each week, to observe the operation of the facility with attention to those aspects cited in this Order, and to submit periodic, written reports to me. The facility shall be liable for the costs of such special monitors until the deficiencies have been corrected and no part of such costs, shall be recoverable, either directly or indirectly, from the Medicaid medical assistance program.

EFFECTIVE at 5:00 p.m. on this 13th day of April, 1987.

JAMES E. WORD
Commissioner

jme4

II-100-84

## COMPLAINT INVESTIGATION

### I. NAME AND ADDRESS OF FACILITY

Belmont Health Care Center
1400 18th Avenue South
Nashville, TN 37213

### II. NAME AND ADDRESS OF COMPLAINANT

[redacted]
Phone: [redacted]

### III. ALLEGATIONS

(1) Mother [redacted] has several bad decubiti. One on left hip was ordered debrided by physician and was not debrided.

(2) Food is brought to room for feeders and left for 2 hours before being fed.

(3) Urine remains on floor for hours before being cleaned up.

(4) Bandages on decubiti are not replaced when they fall off.

(5) Patients are not turned.

(6) Meals are very scant. Saturday, June 2, 1984 evening meal consisted of 2 inch square of jello, 2 slices of stale white bread and 1 scoop of pimento cheese.

(7) Lots of employees do not speak English and are unable to communicate with residents.

(8) [redacted] right foot is bruised, caused by pulling bedrails down on foot.

(9) There are no wash cloths for resident use.

(10) Patients are left up in chairs for hours.

### IV. INVESTIGATION

(a) Date and Time of Investigation

Tuesday - July 3, 1984; 8:30 a.m. to 1:30 p.m. and continued Monday, July 9, 1984 through Wednesday July 11, 1984.

(b) Names of Investigator

Martha Batchelor, R.N.
Olene Underwood, MSW

(c) Announced or Unannounced

Unannounced

(d) Persons Interviewed

Cindy Irwin, R.N., Director of Nursing
R. Newton, LPN, Treatment Nurse, 3rd Floor
Ellaree Stewart, Food Service Supervisor

## V. STATEMENTS CONCERNING COMPLAINT ALLEGATIONS

Complaint investigation was begun on Tuesday, July 3, 1984 at 8:30 a.m. with entrance conference with Cindy Irwin, R.N., DON. Due to existing conditions found in facility on this day, the decision was made by Larry Sanders, Acting Regional Administrator to conduct a full survey on Monday, July 9, 1984. The complaint investigation was completed during the survey.

Allegation (1) - On-site observation of resident [redacted] on 7-3-84 revealed decubiti of both hips approximately 9 cm each, deep and draining; decubitus of cocyx approximately 4-5 cm - deep and draining; decubiti of both feet approximately 3-4 cm each and draining; decubitus on back approximately 4-5 cm and draining. Small open lesions were noted on ears. Review of resident record revealed no written order for debridement by physician. However, during survey on 7-9-84 the nursing progress notes documented the debridement had been performed by the physician on 7-5-84. This allegation was not substantiated.

Allegation (2) - On-site observation of meal service revealed trays served to residents and left at bedside for long periods of time before the resident was fed or assisted with the meal. This was substantiated.

Allegation (3) - Observation of resident rooms and hallways revealed areas of liquid spills and areas of dry, stained material with the appearance and odor of urine. These areas were observed for 2 consecutive days before being cleaned. This allegation was substantiated.

Allegation (4) - On-site inspection and observation of decubiti of residents revealed most decubiti to be covered with proper type dressings. The dressings appeared to be in need of changing as many were saturated with drainage. Four residents with draining lesions observed on 7-3-84 had no dressings on the decubiti. This allegation was substantiated.

Allegation (5) - Continued observation of patient care during survey revealed residents were not being turned, exercised or repositioned on a routine, timely basis. Residents were observed in the same position for as long as 4½ hours without being turned. This allegation was substantiated.

Allegation (6) - Observation of meal preparation and meal service revealed therapeutic diets not being followed as planned and ordered. Food was not being accepted and consumed by all residents. There were not proper substitutions offered to these residents. Servings appeared to be small and the meat appeared hard and and overcooked. This allegation was substantiated.

Allegation (7) - Review of personnel records and observations of nursing personnel revealed the facility does employ approximately 3 nursing assistants from other countries. These employees do speak English and are qualified for thier positions. This allegation was not substantiated.

Allegation (8) - Observation of right foot of [redacted] on 7-3-84 revealed draining decubitus. No bruise was observed. There was no documentation in chart of bruising. This allegation was not substantiated.

Allegation (9) - On-site observation revealed an inadequate supply of linen available. There were no wash cloths found in resident rooms or in clean linen rooms. This allegation was substantiated.

Allegation (10) - Observation revealed residents in Geri-chairs and wheelchairs in rooms and halls for long periods of time. Many of these residents were observed to be restrained. Restraints were not released timely and residents were not exercised or provided a change of position. This allegation was substantiated.

## VI. RECOMMENDATIONS

Allegations 2, 3, 4, 5, 6, 9 and 10 were substantiated. A statement of deficiencies was written during the survey which emcompassed the substantiated allegation including F49, F73, F135, F136, F176, F178, F224, F239, F246, F436, F438, F439, F440 and F445.

Martha Batchelor /les — 8/14/84
Martha Batchelor, R.N. — Date
Public Health Nursing Consulting I

Olene Underwood /les — 8/14/84
Olene Underwood, MSW — Date

CC: Mr. H. John Bonkowski

Facility File

Mr. **Waxman**. Ms. Mettel.

## STATEMENT OF SUE METTEL

Ms. **Mettel**. My name is Sue Mettel, and I thank you for the opportunity to be allowed to speak to you.

My mother is in a nursing home called Oxford Lane in Naperville, IL. We have a family council, which is a group of family members, and we're all unique in that we have a family member who is a resident at this nursing home.

We were asked by one of the administrators—and I say "one of the administrators" because for the past 11 months that I've been involved with this nursing home, we've had five different administrators plus five different directors of nursing plus various different staff members who come and go for weeks at a time.

But during this time period, we have experienced an incredible amount of problems. We were asked to organize our group by the administrator, and he told us that he wanted us to help organize ice cream socials and that type of function when, in fact, we found out later on that he wanted us to be organized, so they could get points for the QUIP program that public aid has, and because of our participation there, we would hold monthly meetings there where we had different family members come, and we've had up to 60 family members each month come to these meetings. They would get points for that, and because of that, they became a two-star facility instead of a one-star, which is what they were prior to us organizing.

But during the course of these meetings, we found out a lot of information from other family members, and we have documented from different family members such incidents as one resident who was observed with handcuffs on. Another resident was strapped down to her chair, so that an orderly could trim her fingernails, but after he got done, she had bruises all over her arms from where she was strapped down.

We had another family member who brought her mother back after visiting her, and when she came into her room that night, one of her roommates had died during the course of the day, and they did not remove the body until the next morning, so the two residents were forced to sleep overnight with a dead person between them. And during the course of the evening, different aides came in and pointed out the fact to other aides that there was a dead person in the room with them.

We had a resident recently who just had to have her leg amputated, because she had bed sores that were so infected, and she also was malnutritioned, which is interesting as she'd been a resident there for 6 years.

We also had just recently two residents who died. One died in December and one died in February from dehydration. And after talks with the administrator of the facility, she told me they were so understaffed that they had to do things—they had to cut back on some of the services they provided, such as IV's, and it is our contention that these people were on IV's, and that they died as a result of the lack of care that they were getting.

We also have a family member who noticed that her mother had a lump in her abdomen, and she pointed it out repeatedly to the different staff at the nursing home, but they did nothing about it. Finally, after 5 months had gone by, the family member was so incensed that she had her sent to the hospital where the mother died 2 days later from cancer.

When all of this was going on, we tried very hard to work with the administrator of the facility. We invited them to meetings. We tried to follow whatever suggestions they had, but their answer to us was, "Be patient. We know we have problems here. We know we have a staffing problem, and you're going to have to be patient while we try to work this out."

Well, we were patient for 11 months. But in February, we decided we couldn't be patient any longer, now that we had some of our family members dying as a lack of their care, and it was just fortunate for us that one of our family members called the nursing home hot line, which was run by the Public Health Department in Springfield, bypassing the local Public Health Department, and we called with complaints about the facility, and they sent out a representative from Prairie State Legal Services, which is a not-for-profit organization in Illinois, where they advised us what our residents' rights were, especially regarding discharge. The nursing home had, during February for 2 weeks, called up 40 of us family members saying that "we are so understaffed, you are going to move your resident. You have 10 days to do it."

Well, we found out that was illegal, and we also found out there were other legal measures that we could take. One of the measures that we considered was having a receiver appointed. We didn't really want to do that, in that we'd had so many other people running the nursing home. We'd had five administrators during this 11-month period. But we felt this was the only way to go, so we did hire an attorney, an independent attorney by the name of Stephen Levine, and we did go to court to have an emergency hearing to have a receiver appointed.

Well, obviously the nursing home didn't want to do that, so they agreed, and we did settle out of court. But it did take a lot of work and continuous efforts on our part to see this legal action through, and it was only because of this legal action that Oxford Lane was not totally decertified. They were decertified, but not totally

[Testimony resumes on p. 261.]

[The prepared statement and attachments of Ms. Mettel follow:]

## TESTIMONY OF SUE METTEL, PRESIDENT OF THE OXFORD LANE FAMILY COUNCIL
BEFORE THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
U.S. HOUSE OF REPRESENTATIVES ENERGY AND COMMERCE COMMITTEE 5-12-87

I wish to thank the House Select Committee on Aging and Congressman Waxman for addressing this important legislation on behalf of nursing home residents and for allowing the Oxford Lane Family Group to provide testimony on this issue.

My name is Sue Mettel, President of the Oxford Lane Family Council. Oxford Lane is a 205-bed facility located in Naperville, Illinois. The Council is composed of over 45 active family members. This Family Council was originally formed by an administrator of the facility for the purpose of providing volunteers in the facility. We learned later that this volunteer program was instituted not necessarily in good faith for the improvement of the quality of life for those residents in the facility, but to increase the facility's reimbursement according to State Medicaid Program guidelines.

I would now like to backtrack somewhat and explain my involvement in Oxford Lane. My mother, whose diagnosis is organic brain dysfunction, was admitted to Oxford Lane from another facility in DuPage County. This other facility claimed that they were withdrawing from the Medicaid Program, and therefore all of their Medicaid residents had to be discharged to facilities with current Medicaid Provider Agreements. However, since the only source of payment for my mother's care was Medicaid, I was advised to select another facility that would accept Medicaid. I only recently learned that this facility, claiming to be withdrawing from the Medicaid Program, remains a fully-certified Medicaid provider.

In my search for a facility willing to accept Medicaid upon admission, I found only a very few facilities open to accept these terms in my immediate area. In fact, most facilities in my county are requiring some duration of stay provision prior to conversion to Medicaid. This, I also learned later, was in contradiction to current state law regarding Medicaid discrimination. Considering my limited accessibility to a large number of Medicaid facilities, I then selected Oxford Lane for my mother.

Upon admission to this facility, I soon learned of problems confronting either my mother or other residents of a most alarming nature. The facility always looked clean, and on the surface, there appeared to be no visual problems on structural grounds.

However, frequently I observed the facility with a serious staff shortage on both floors. Members of the Council observed new staff members on a regular basis providing care to their family members, many of whom would be without name tags. We soon learned the reason behind this policy was that the facility would hire temporary agency staff to meet state minimum standards. If not enough agency staff could be hired that day, there simply would not be staff available to all residents. Residents would then suffer from the fact that staffing requirements would not be met. As a result of this staff shortage, frequent cases of infected bedsores were reported, medication was not being given as prescribed, diets were not being adhered to, and residents were not being fed to insure proper nutrition.

I would also like to comment further on some of the specific incidents experienced by members of the Council.

- First, a resident was observed handcuffed as a form of punishment.
- On another occasion, a resident was strapped down with tight restraints in order that an orderly could trim her nails resulting in bruises on the resident's forearms.
- Another resident, upon returning from a visitation with family, was forced to spend the evening with a dead resident in the bed next to her. Throughout the evening, the resident was constantly reminded by the staff of the other resident's death. Removal of the body was not until the next day.
- Another resident who had been there for four years just recently had her leg amputated due to complications with an infected bedsore and malnutrition.
- Two residents died in December and February due to dehydration. It was during this time period that the Administrator confirmed in a telephone call to me that due to staff shortages, IV's were being pulled.

- Another family member noticed that her resident had a lump in her abdomen. The family member immediately pointed it out to the staff and had it documented on the resident's chart. However, five months later nothing had been done about the condition which was worsening. Finally, the family member insisted her resident be hospitalized, and the resident died two days later from ovarian cancer.

After observing these experiences of not only lack of respect and dignity but pure sadism -- not to mention neglect -- the Council attempted to meet with administration and resolve these problems, without much success. We were told by the management and owners of the facility that they were aware that they had serious problems at the facility, but we were asked to be patient while they rectified the problems. However, while we were being patient, the problems not only continued, but got worse.

As family members, we felt both a sense of helplessness and frustration for both our relatives in the facility and for ourselves. We had entrusted the care of our relatives to those in control of the facility in good faith. However, our frustration would soon accelerate into anger as we discovered that in March, 1987, participation in the Medicare Program was withdrawn and the skilled care unit was subsequently decertified for Medicaid reimbursement.

As many members of the Council had similar experiences in placing their relatives as I did, we began to fear for the next step. Where would these skilled care residents be placed? What implication would this decertification have on our residents on the intermediate care floors? Out of 170 residents at Oxford Lane in March, 150 were Medicaid recipients. As a group, we discussed possibilities of placement for our relatives. As an example, one family member finally found a facility which would take her resident, but the facility was over 50 miles from her immediate area making regular visitation almost impossible.

As a result of our panic, some of our members contacted both Illinois Citizens for Better Care, an independent consumer organization on behalf of nursing home residents, and Prairie State Legal Services for both assistance and advice in our dilemma. We were immediately advised of our rights in regard to discharge according to Illinois statute. Private organized meetings of the Family Council were undertaken with the assistance from Illinois Citizens for Better Care at a local church. As a consequence of these meetings, the option of petitioning for a receiver was discussed. It was then decided unanimously by the Council that our only realistic option to undertake on behalf of our relatives was to petition the court for a receiver to be appointed. The private counsel of Mr. Steven M. Levin was engaged for this specific purpose. Since the State failed to initiate any action of this nature, we assumed that we were the most feasible body to initiate this action.

What the Family Council discovered in these meetings expecially dismayed our members. It was learned that deficiencies of a serious nature against the facility dated as far back as 1984. I have provided for your review copies of surveys, a complaint investigation, and summaries of Illinois State Violators Lists. As you will discover, much of the data indicates a repetition of deficiencies have occurred.

The next question confronting our members was the reason state enforcement mechanisms failed to act promptly on circumstances beneficial to the nursing home. Can a situation such as ours be avoided? It seems to us that negotiation and arbitration between the facility and the Department of Public Health only prolonged the hardship forced upon our relatives. How long does a problem have to exist in a facility before any action is undertaken? It is our opinion that simply closing a facility does not rectify the problem for nursing home residents. Can we afford to play "musical chairs" with their lives? The role of receiver seems to play the most important role in this area.

It was only through our Council's continuous effort that the State appointed a monitor to this facility for thirty days. Our concern as a Council now is what happens to our relatives after the thirty days. Can we be guaranteed that the facility will continue its appropriate procedures at this time, and can we ensure that the State will be able to provide proper enforcement and monitor this facility following the thirty-day period?

For these reasons, we would like to convey to this Committee that not every facility has such an active Family Council to undertake this type of action on its own initiative. It is our opinion as citizens of Illinois that the government must ensure that nursing home residents are not forced to live in life-threatening conditions at any time. We urge this Committee and its members to ensure these rights to all residents in nursing homes everywhere.

Quarterly List
OCTOBER - DECEMBER 1986

The following facility has been determined to be in violation of the Nursing Home Care Reform Act and/or Federal requirements for participation in the Medicare and/or Medicaid Program:

Facility Name: Oxford Lane
Facility Address: 1525 Oxford Lane
Naperville, IL 60565
Docket #

Name of Owner or licensee: Oxford Lane - Ltd.
Kenneth J. Fisch
Address: 221 N. LaSalle - 37th Floor
Chicago, IL 60601

Consequently, the Illinois Department of Public Health has initiated one or more of the following actions as indicated by boxes marked with X:

Date of Action

1. Sent a notice of penalty assessment for:
   - ☐ Type "A" violation(s).
   - ☐ Repeat violations.

☐ 2. Sent a notice of license revocation.

☐ 3. Sent a notice refusing renewal of a license.

☐ 4. Sent a notice to suspend a license.

☐ 5. Issued a conditional license for violations and penalties.

☐ 6. Placed a monitor under subsections (a), (b) and (c) of Section 3-501 and under subsection (d) of such Section where license revocation or nonrenewal notices have also been issued:

☐ 7. Initiated an action to appoint a receiver:

☒ 8. Recommended to the Director of the Department of Public Aid, or the Secretary of the United States Department of Health and Human Services, the decertification for violations in relation to patient care of a facility pursuant to Titles XVIII and XIX of the federal Social Security Act: 12/30/86

Reason for the action(s): Violation(s) relating to area of nursing.

Amount of penalty sought:

Disposition: Pending

IL 482-0496

1400/6183P

Quarterly List
October-December, 1985

The following facility has been determined to be in violation of the Nursing Home Care Reform Act and/or Federal requirements for participation in the Medicare and/or Medicaid Program:

Facility Name: Oxford Lane Nursing Home. Ltd.
Facility Address: 1525 South Oxford Lane
Naperville, IL 60563
Name of Owner or licensee: Oxford Lane Ltd. c/o Kenneth J. Fisc
Address: 3500 West Peterson Avenue
Chicago, IL 60659

Consequently, the Illinois Department of Public Health has initiated one or more of the following actions as indicated by boxes marked with X:

Date of Actio

1. Sent a notice of penalty assessment for:
   ☐ Type "A" violation
   ☒ Repeat violations. 12/31/85

☐ 2. Sent a notice of license revocation.

☐ 3. Sent a notice refusing renewal of a license.

☐ 4. Sent a notice to suspend a license.

☒ 5. Issued a conditional license for violations and penalties. 12/31/85

☐ 6. Placed a monitor under subsections (a), (b) and (c) of Section 3-501 and under subsection (d) of such Section where license revocation or nonrenewal notices have also been issued:

☐ 7. Initiated an action to appoint a receiver:

☐ 8. Recommended to the Director of the Department of Public Aid, or the Secretary of the United States Department of Health and Human Services, the decertification for violations in relation to patient care of a facility pursuant to Titles XVIII and XIX of the federal Social Security Act:

Reason for the action(s): Violation(s) relating to area of nursing and sanitation.

Amount of penalty sought: $11,927.40

Final Disposition: Pending

IL 482-0496

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF ENFORCEMENT
FACILITIES WITH VALID A DIFFICIENCES FOR FISCAL YEAR 1984

| FACILITY NAME<br>LOCATION | COMPLAINT RECEIVED | A | B | N | S | COMP NUMBER | DISP CODE | DATE OF INSPECT | DATE OF DETERM | VALI |
|---|---|---|---|---|---|---|---|---|---|---|
| SCHAUMBURG | | | | | | | | | | |
| OXFORD LANE NURSING HOME LTD<br>NAPERVILLE | 01/11/84 | N/A | N/A | N/A | N/A | 8471352 | C | 02/02/84 | 02/23/84 | Y |
| NAPERVILLE | 01/30/84 | N/A | N/A | N/A | N/A | 8471424 | C | 02/02/84 | 02/23/84 | Y |

Attorney #1337

STATE OF ILLINOIS )
) SS.
COUNTY OF DU-PAGE )

IN THE CIRCUIT COURT OF THE EIGHTEENTH JUDICIAL CIRCUIT

SUE METTEL, NOREEN FITZGERALD, MARY WALTER, CAROL J. McGUIRE, and LYNDA JOHNSON,

Plaintiffs,

-vs-

OXFORD LANE, LTD., an Illinois Corporation, ALDEN CARE, LTD., an Illinois Corporation, and ALDEN MANAGEMENT SERVICES, INC., an Illinois Corporation, DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, a public entity, and DEPARTMENT OF PUBLIC AID, STATE OF ILLINOIS, a public entity,

Defendants.

NO:

87CH 0246

## COMPLAINT FOR RECEIVERSHIP AND INJUNCTIVE RELIEF

The Plaintiffs, SUE METTEL, NOREEN FITZGERALD, MARY WALTER, CAROL J. McGUIRE, and LYNDA JOHNSON, by their attorneys, STEVEN M. LEVIN & ASSOCIATES, complain against Defendants, OXFORD LANE, LTD., an Illinois Corporation, ALDEN CARE, LTD., an Illinois Corporation, and ALDEN MANAGEMENT SERVICES, INC., an Illinois Corporation, DEPARTMENT OF PUBLIC HEALTH, STATE OF ILLINOIS, a public entity, and DEPARTMENT OF PUBLIC AID, STATE OF ILLINOIS, a public entity and state as follows:

### THE PARTIES

## FACTUAL BACKGROUND

31. The facility was at all times relevant to this Complaint a long-term nursing home facility.

32. At all times relevant to this Complaint, the **OXFORD LANE** facility was operated by its officers, employees, agents, and staff for the purpose of providing professional residential care and nursing treatment to its residents.

33. At all times relevant to this Complaint, the facility was a "facility" as defined by Ill.Rev.Stat., Ch. 111-1/2, Sec. 4151-113 of the Nursing Home Care Reform Act of 1979, as amended ("the Act"), and defendant **OXFORD LANE**, was subject to the requirements of the Act (Ill.Rev.Stat., Ch. 111-1/2, Sec. 4151-101 et. seq.) and the regulations of the Illinois Department of Public Health ("IDPH") promulgated pursuant to the Act.

34. The facility is licensed by the State of Illinois and since at least December, 1986, has been operating under a conditional license.

35. For a period of time and continuing to the present date, the facility was licensed as both a skilled-care and an intermediate-care facility.

36. Prior to a date in approximately the beginning of March, 1987, **OXFORD LANE** was certified for participation in the Medicare Program of the Government of the United States.

37. For a period of time and continuing to the present

date, **OXFORD LANE** has been certified to participate in the Medicaid Program, administered by the State of Illinois.

38. On information and belief, for a period of time each of the nursing homes owned, operated, managed, or otherwise controlled by defendant **ALDEN CARE**, including nursing homes listed in Paragraph #2 above, were participants in the Medicaid programs.

39. Prior to December, 1986, the facility was found to have violated the regulations of the IDPH by being understaffed, by failing to have the proper administrative staff, and otherwise by failing to provide the proper care and treatment of residents.

40. In September, 1986, inspectors from the IDPH made an extensive survey of the facility and found numerous deficiencies and violations of the requirements of the Act and the regulations of the IDPH. A copy of the deficiencies and "Plan of Corrections" submitted by the administrators of the facility are attached to this Complaint as Exhibits "A" and "B".

41. Among the deficiencies found were serious understaffing and untrained staff (see Exhibit "A", Pgs. 4 and 5); failure to properly feed and record the food and liquid intake of residents (see Exhibit "A", Pg. 8); failure to give treatments, medications, and diets as prescribed (see Exhibit "B", Pgs. 19 through 22); and failure to give the care necessary to prevent the development or worsening of decubitus ulcers (see Exhibit "B", Pg. 22).

42. For a period of time, a family support group known as the "Oxford Lane Family Support Group", composed of family members of residents of the facility has been acting to secure appropriate treatment for their relatives at the facility and has met with management in order to work towards this end.

43. Subsequent to the publication of the September survey of the IDPH, on September 25, 1986, Floyd A. Schlossberg sent a letter on the stationery of defendant **ALDEN MANAGEMENT SERVICES, INC.**, to the Oxford Lane Family Support Group, which letter indicated the problems at the facility were "our fault" and that defendant **ALDEN MANAGEMENT SERVICES, INC.**, had targeted six months to correct the deficiencies. A copy of this letter is attached to this Complaint as Exhibit "C".

44. For a long period of time, including the period from September, 1986, and continuing to the present date, there have been and continue to be numerous incidents of abuse and neglect of residents of **OXFORD LANE**, which acts violate the Nursing Home Care Reform Act, Ch. 111-1/2, Sec. 4152-107, Ill.Rev.Stat.

45. In November and December, 1986, inspectors from the IDPH again visited the facility and found that the Plan of Corrections of September, 1986, had not been adequately implemented and that there were numerous repeat violations. A copy of part of the findings of "Deficiencies Not Corrected" is attached to this Complaint as Exhibit "D".

46. In November and December, 1986, surveys of the facility by inspectors from the IDPH found additional violations,

including the failure to have a registered nurse on the day shift seven days per week. A copy of these findings are attached to this Complaint as Exhibit "E".

47. Beginning on a date unknown to plaintiffs at this time, defendants ceased providing certain nursing care to some of its residents, failed to provide I.V. tubes for residents with orders for I.V.'s, and otherwise cut back on the nursing services required by certain of its residents, including the refusal to provide nasal gastric feeding.

48. On or about March 4, 1987, Plaintiff, Sue Mettel, was told by facility Administrator, Holly Striska, that I.V. treatment was not being administered because of a lack of staff.

49. During a period including approximately five days during the second week of February, 1986, defendants engaged in a concerted effort to discharge from the facility at least 35 skilled-care residents as well as certain intermediate-care residents.

50. Family members of certain residents of the facility were telephoned or otherwise informed by Mary Moreau, then the Director of Nursing at the facility and other employees of defendant, that the facility did not have a staff to adequately care for their residents.

51. Certain family members were told that there was a need to move residents out of the facility because of redecorating plans.

52. Various family members were told that the residents in question should be moved within a period of ten days and that defendant **ALDEN MANAGEMENT SERVICES**, INC., or its employees should be notified within approximately two days whether the resident was going to be moved.

53. As a result of these calls or other communications, approximately 18 skilled-care residents were transferred out of the facility in or about February, 1986.

54. During the past several months, a number of residents have transferred from the facility because they have been told or they or their relatives have observed the treatment was utterly inadequate and a threat to health and safety of their family members.

55. In November, 1986, Plaintiff, Mary Walter, transferred her father, Cormac Wiseman, from the facility involuntarily because she observed, inter alia, that he was not receiving the level of skilled-care he required and had been abused, neglected, and otherwise improperly and illegally treated and cared for.

56. The transfer of these residents was involuntary in that these transfers were coerced, inter alia, by threats that proper care was not or would not be given to the particular residents and by the failure, in fact, to provide proper care, which failure was observed by certain residents or the relatives and/or guardians.

57. The transfer of these residents was illegal in that it was not performed in accordance with the requirements of the Act

for involuntary transfer, Ch. 111-1/2, Sec. 401 et. seq., Ill.Rev.Stat.

58. Defendants closed part of their facility by discharging more than 10% of their skilled-care residents without complying with the 90 day notice requirement and other provisions of Ch. 111-1/2, Sec. 3-423, Ill.Rev.Stat.

59. Doris Harper is Resident Care Section Supervisor of Region 7 of the Division of Long-Term Field Operations of IDPH.

60. During the period in or about February, 1987, when defendants were "asking" residents to leave the facility because, inter alia, proper care could not be provided, defendant IDPH violated its statutory duties in a number of ways:

(a) Doris Harper informed facility employees that the transfer demands or requests were proper and in accordance with law, when such was not the case;

(b) Doris Harper informed OXFORD LANE residents and/or their families that such discharges were proper and in accordance with law, when such was not the case;

(c) Other unknown employees of IDPH helped and/or acquiesced in the discharges contrary to law;

(d) Defendant IDPH allowed the discharge of residents of the facility in violation of Ch. 111-1/2, Sec. 401 et. seq., Ill.Rev.Stat., regarding the involuntary transfer of residents;

(e) Defendant IDPH allowed the discharge of residents of the facility in violation of Ch. 111-1/2, Sec. 423, Ill.Rev.Stat., in that the facility closed part of its facility without following the requirements of that statutory scheme.

61. When IDPH cooperated in bringing about these transfers it was known to the IDPH employees involved that the transfers were being made contrary to law.

62. During the period in or about February, 1987, when defendants were "asking" residents to leave the facility because, inter alia, proper care could not be provided, defendant IDPA violated its statutory duties in a number of ways:

(a) Employees of IDPA informed the facility and/or residents or their families that the discharge demands or requests were proper and in accordance with law, when such was not the case;

(b) IDPA continued to pay for the care of Medicaid residents of the facility when it was known that illegal discharges were taking place.

63. Defendant IDPA continues to pay for the care of residents of the facility when it knows that the contracted-for care for which it is paying has not been and is currently not being provided both at the skilled-care and intermediate-care level.

64. Defendant OXFORD LANE appears on the IDPH'S October-December, 1986, "Violator's List" (list of facilities in violation of the Nursing Home Care Reform Act and/or federal requirements for participation in the Medicare and/or Medicaid Program) for:

(a) Repeat violations (date of action-December 9, 1986);

(b) Issued a conditional license for violations and penalties (date of action-December 9, 1986);

(c) Recommended to the Director of the Department of Public Aid, or the Secretary of the United States Department of Health and Human Services, the decertification for violations in relation to patient care of a facility pursuant to titles XVIII and XIX of the Federal Social Security Act (date of action-December 30, 1986).

65. In or about the second week of March, 1986, the Health Care Financing Administration of the U.S. Department of Health and Human Services decertified the facility as a skilled-care facility, basing its actions on the December IDPH surveys.

66. As a result of this federal action, the facility can accept no new Medicare patients requiring skilled-care.

67. On information and belief, there are currently approximately 10 residents of the facility classified as skilled-care residents.

68. On information and belief, each of these residents is a Medicaid patient.

69. At the current time, the status of the immediate future of these skilled-care residents is unknown; and this fact is a source of great concern and fear to these residents and/or their families.

70. On information and belief, personnel of IDPH have begun some action to require or recommend the transfer of these skilled-care residents out of the facility.

71. On information and belief, there is an acute shortage of Medicaid beds for skilled-care residents in DuPage County, and in the entire area surrounding Chicago, and thus such residents needing to transfer would find it difficult, time-consuming, and perhaps impossible to find appropriate nursing home placement near their families.

72. On information and belief, defendants have operated their skilled-care facility as they have done for a period of time with the aim of closing down this part of their facility or being "forced" to close down this part of their facility.

73. Conditions for intermediate care residents as well as skilled-care residents of the facility continue to violate the law and pose a serious danger to the health and safety of these residents in that, inter alia:

(a) The September "Plan of Corrections" has not been implemented to a significant degree;

(b) Intermediate-care residents have also been asked to leave the facility "voluntarily" because according to employees of defendant, **ALDEN MANAGEMENT**, adequate care cannot be provided to them;

(c) On information and belief, there are residents classified as intermediate-care residents who need or soon will need to become skilled-care residents;

(d) The Administrator of the facility has informed one family member that the facility is not able to handle the care of its many patients with decubitus ulcers and that they want to move such patients out of the facility;

(e) On or about March 23, 1987, a resident's relative observed that there was no water available by the bedsides of residents of the second floor of the facility, a violation of the standard of care which has occurred repeatedly.

74. On or about March 4 - 6, 1987, Holly Striska, the current Administrator of the facility told one or more residents' relatives that if they called the IDPH Hot Line or Prairie State Legal Services to complain about conditions in the facility, the facility would be forced to close.

75. On information and belief, a resident of the facility died within the last four months as a result of not receiving any fluid intake for approximately four days.

76. On information and belief, during the past six months there have been at least 3 other deaths at the facility under circumstances, indicating lack of proper care.

77. On information and belief, tranquilizers were and continue to be administered at night to patients for no medical purpose, but because there was insufficient staff.

78. On information and belief, there was an incident at the facility in or about September, 1986, in which someone put paint thinner in place of a topical medicine on a medicine cart, the "medicine" was administered and a resident suffered burns therefrom.

79. On information and belief, handcuffs were illegally used by facility personnel to restrain residents.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | | | |
|---|---|---|---|
| (X1) PROVIDER NUMBER | 14-5375 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING ______ | (X3) DATE SURVEY COMPLETED<br>9-15-86 |

NAME OF PROVIDER OR SUPPLIER: Offutt Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Offutt Lane, Sugarville, Ill. 60565

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 75<br>1121<br>45<br>1121 h | Residents are not always treated with respect, consideration and full recognition of their dignity and individuality as evidenced by: Res#810 A full bedpan was observed beside residents breakfast tray. Res# 1183 stated to surveyor that staff speak to one another in a foreign language while feeding residents, who also feels she is being discussed. Resident she is unable to feed self. Res#822 has 6 items in closet which are not marked with her name. Res.#532 was observed wearing roommate's sweater. Res#1027 identified sweater by safety pin on pocket. Sweater had not been marked or labeled with residents' name. (continued) | F 75<br>405.1121<br>F 245<br>405.1121 h | The facility staff will treat residents with respect, consideration, and dignity at all times. An inservice was held for nursing staff on 9/16/86 which included:<br>1. proper method of serving trays.<br>2. not speaking a foreign language that excludes the resident being cared for.<br>3. checking for incontinence before bringing in trays.<br>A repeat inservice will be held on 9/18/86.<br>The activities department has secured a volunteer to mark all clothing now in the facility. Families of new admissions will be informed by the Admissions Director that all clothing items must be marked with the resident's name. Family council will be advised of the labeling necessity at their meeting on 9/22/86.<br>The Administrator, D.O.N. and A.D.O.N. will monitor, as well as floor nurses. | 9/21/86<br>9/22/86<br>9/22/86 |

| | | |
|---|---|---|
| PROVIDER REPRESENTATIVE'S SIGNATURE<br>Wm Calhoun | TITLE<br>Agent of Offutt Lane | (X6) DATE<br>9-15-86 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM HCFA-2567 (10-84)

HCFA REGIONAL OFFICE

If continuation sheet Page ___ of ___

EXHIBIT "A"

"STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION"

ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____
B. WING ____

OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

| PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
|  | (continued) |  |  |  |
| 75<br>1121<br>15<br>121K | Res# 1129 - 3 unmarked clothing items in closet. Res# 943 smelled of feces prior to serving breakfast, had his breakfast in that condition, was checked after breakfast, and indeed, had been incontinent of stool. Res# 010 - Had consumed his breakfast smelling of urine; it had been determined at the time of feeding that he was incontinent of urine. 9-10-86 8:30 am. |  |  |  |

| | | REVIEWED BY (INITIALS) | DATE | PROVIDER REPRESENTATIVE'S SIGNATURE | (X6) DATE |
|---|---|---|---|---|---|
| ED BY STATE CERTIFYING AGENCY | ☐ | | | William Calliari | 9/15/86 |
| ROVED BY STATE CERTIFYING AGENCY | ☐ | | | | |
| | | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | |
| ED BY DHHS REGIONAL OFFICE | ☐ | | | Agent of Oxford Lane | |
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deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting ding it is determined that other safeguards provide sufficient protection to the patients. reverse for further instructions.)

2 of 30

HCFA-2567 (11-83)

AND HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB No. [illegible]

## EMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | | | |
|---|---|---|---|
| (X1) PROVIDER NUMBER | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
| 14 - 5375 | A. BUILDING ____ <br> B. WING ____ | | 9/15/86 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| Oxford Lane Nursing Center | 1525 Oxford Lane | Naperville, Ill. 60565 | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 99 <br> 05.1123 <br> 120 <br> 5.1124 | Residents # 980 and # 889 have no physicians orders to have their indwelling foley catheters — no orders on the physicians order sheets, no evaluation or diagnosis of need for their foley catheters is documented. | F 99 <br> 405. 1123 <br> F 120 <br> 405. 1124 | Physician's orders will be current for all Foley catheters. Records will include evaluation and diagnosis of need for Foley catheters. This information will be documented. <br> D.O.N., A.D.O.N. and Resident Care Coordinator will monitor. | 9/30/86 |

| | | |
|---|---|---|
| PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| William Calliari | Agent of Oxford Lane | 9/30/86 <br> 9-30 |

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ORM HCFA-2567 (10-84)

H AND HUMAN SERVICES
ING ADMINISTRATION

# .EMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____
B. WING ____

(X3) DATE SURVEY COMPLETED: 9/15/86

ME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane Naperville, Ill. 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 26<br>1125 | Weekly nursing time schedules do not clearly identify relief personnel by name. Master schedule is not maintained to show coverage when staff are absent. | F126<br>405.<br>1125 | A master schedule showing staff coverage and substitutes will be maintained in the D.O.N.s office. Administrator will monitor. | 9/16/86 |
| 30<br>1124 | Charge nurse is not indicated when the RN is off duty on 3-11 and 11-7 schedule, 2 or 3 LPN's are on duty without the charge nurse designated by the DON. | F 130<br>405.<br>1124 | The charge nurse will be designated on each shift and in the master schedule. D.O.N. will monitor. | 9/16/86 |
| 1 F113<br>1124(c)<br>127<br>5. 1124<br>)<br>ICARE<br>1121(h)<br>243<br>241<br>245 | —as evidenced by other deficiencies written; Facility does not have sufficient trained staff to meet the total needs of all residents. There is a turnover of staff — acting DON of one week. Acting Adm due to illness of administrator, FSS on duty for 1 month. — Facility relies on CNA from other facilities to fill out staff schedule, they are unfamiliar with the residents and care plans are not all complete and updated to give them a good source of reference as to care needed | F 111<br>F 113<br>405.<br>1124<br>(c)<br>F 127<br>405.<br>1124<br>Reference to<br>405.<br>1121<br>(h)<br>F 243 | A permanent assistant administrator has been appointed. D.O.N. applicants for permanent position are currently being interviewed. An IDPH approved Certified Nurses Aide training course is starting in house 10/7/86 by the College of DuPage on a permanent basis in order to assure adequate CNA staffing at all times. At this time, addition CNA's above and beyond required staffing are being schedule to assure that we are meeting resident needs. Professional staffing has been increased 7 days per week. The Operation Manager from the management company plus other executives have been assigned to Oxford Lane daily until staff is stabilized.<br>F 244 F 245 | |

(continued on next page)

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|---|---|---|
| OVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| illiam Calliaci | Agent of Oxford Lane | 9/15/86 |

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RM HCFA-2567 (10-84)

HCFA REGIONAL OFFICE

If continuation sheet Page of

…D HUMAN SERVICES
…ADMINISTRATION

## …MENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14 - 5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____
B. WING ____

(X3) DATE SURVEY COMPLETED: 9/15/86

…OF PROVIDER OR SUPPLIER: Ford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane Naperville, ILL. 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| .190<br>5.1125 | Residents were not served appropriate substitutes on 9/9/86 — lunch entree was pepper steak and rice.<br>R# 425 and R512 — tray cards state 'no rice' and both residents received rice on lunch entree.<br>R1071 — tray card states no corn and resident received corn on tray.<br>R653 and R425 often refuse lunch — on this day no substitutes were offered and their trays were left on a table in 1st floor dining room. | F 111,<br>F 243 | F 113, 405.1124 (c), F 127, 405.1124, Reference to 405.1121 (h)<br>(continued from previous page)<br>Admissions have been curtailed and no skilled or Medicare residents will be admitted until staff is stabilized.<br>Coverage will be provided for all shifts, and staff unfamiliar with residents will be assisted by:<br>1. Oral reports at the beginning of shift.<br>2. I.D. bands in place on all residents. Refusals will be documented.<br>3. RN has been started 5 days per week in a new position as Resident Care Coordinator to update care plans.<br>4. Clear assignments for CNA's on all shifts.<br>The D.O.N. and A.D.O.N. will monitor. | 9/30/86 |
|  |  | F 190<br>405.<br>1125 | *Substitute items will be listed on daily menu and resident trays will reflect food preferences and substitutes.<br>*New diet cards are ordered and will allow more room for statements of food preferences. Staff will be inserviced on appropriate substitutions and proper reading of diet cards. Food Service Supervisor will monitor tray line service for tray accuracy and a designated inserviced individual will do so in the absence of the Supervisor. Inservice on 9/29/86 |  |
| .191<br>.193<br>5.1125(d) | The evening meal is scheduled for 5PM but was not brought to 2nd floor until 6:05PM on 9/10. 2 residents were still being fed at 7PM. Resident # 695 — Tray observed still on cart ~~at~~ 6:55PM — resident needs to be fed. Two daily monitors stated meals late for 3 days. | F 191<br>F 193<br>405.<br>1125<br>(d) | *The evening meal time is scheduled for 5:30 p.m. and the dining hours will be posted as such. Meal time will be announced so both residents and staff are aware that trays are being served. Staff meal times have been changed to 4:30p.m.-5:00p.m. so staff meals are not during resident meal time. Feeder trays are being sent on last cart so more aides are available to help feed. | 10/15/86 |
| 5.194<br>1125 | No bedtime nourishments are offered — juice is on the floor but residents are not routinely offered a snack. Resident 1009 was not offered juice on 9/9 — chart - must be fed. |  |  |  |

…OVIDER REPRESENTATIVE'S SIGNATURE: William Calliari

TITLE: Agent for Oxford Lane

(X6) DATE: 9/15/86

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HCFA REGIONAL OFFICE

If continuation sheet Page __ of __

UMAN SERVICES
MINISTRATION

# ENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9/15/86

E OF PROVIDER OR SUPPLIER: xford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane Naperville, Ill. 60565

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|---|---|---|---|---|
| 162<br>163<br>1124(f)<br>5 | The adequacy of daily food and fluid intake of residents is not monitored or recorded by nursing on a daily basis. Facility has no form presently in use for aides to document percentile eaten.<br>Tray cards are routinely removed when trays are served and nothing is marked down as the trays are removed. Observed a resident picking up trays and putting them on cart, housekeeper was observed picking up trays on 2nd floor at 7PM and resident # 701 was observed eating off of 3 different trays — no one from nursing intervened and no one was observed supervising to ensure that each resident was fed. | F 194<br>405.<br>1125<br>F 162<br>F 163<br>405.<br>1124<br>(f)<br>F 165 | *The Food Service Supervisor will make sure that nourishments are sent to the floors daily after the evening meal.<br>*A form documenting resident's daily intake will be used as of 9/30/86. This form will document percentile eaten. Nursing services will fill in this form and Food Service Supervisor will check it.<br>*Tray cards will be left on trays, and when trays are removed, uneaten portions will be documented on daily intake form. The nursing staff will be inserviced on proper use of this form and on identification of various diet cards. Inservice on 9/29/86 by Dietary Coordinator.<br>*Each dining area will have a meal monitor to document food and fluid intake and to ensure that residents are fed. The staff will be inserviced on 9/29/86 as to proper use of the meal monitor form and methods of feeding residents will also be assessed.<br>*A count of all resident's diet cards will be taken after each meal by the Food Service Supervisor to ensure that all residents receive a tray at the proper meal times. (Or by the FSS Designee) | 10/15/86<br>9/30/86<br>9/29/86<br>9/29/86<br>9/30/86 |
| 164 | Prompt assistance was not provided for each resident — observed —<br>R 603 – Trying to eat pureed food with her knife.<br>R 943 – no lunch tray at 1:20PM – resident in bed – everyone put on call light and asked for his tray.<br>R 889 – poorly positioned in bed eating breakfast with her fingers at 10:[illegible] AM | F 164 | *Food Service Supervisor will work with the Occupational Therapist on providing appropriate eating assistance devices for the residents. Dietary staff will be given a list of the residents requiring assistive devices and will be inserviced on the types of assistive devices and when to put these devices on the designated resident's tray. An inservice on this will be held on 9/29/86. Bibs are now available for residents and nursing staff have been inserviced as to their use on 9/16/86. (continued) | |

OVIDER REPRESENTATIVE'S SIGNATURE: William Calliari

TITLE: Agent of Oxford Lane

(X6) DATE: 9/15/86

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everse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to
ntinued program participation.

FORM APPROVED

## ENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | |
|---|---|
| (X1) PROVIDER NUMBER | 14-5375 |
| (X2) MULTIPLE CONSTRUCTION | A. BUILDING ______ B. WING ______ |
| (X3) DATE SURVEY COMPLETED | 9/15/86 |
| NAME OF PROVIDER OR SUPPLIER | xford Lane Nursing Center |
| STREET ADDRESS, CITY, STATE, ZIP CODE | 1525 Oxford Lane Naperville, Ill. 60565 |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| -164 | Continued —<br>Resident #890 was spilling dish of fruit down front of her dress in 2nd floor feeder room. No plate guard was provided for her and she was pushing her food off her plate while trying to feed herself.<br>No assistive devices such as plate guards, built up plates or special spoons, forks or knives are used for any residents in the facility.<br>Food spills observed on residents — no bibs for residents in any of the dining areas to protect residents clothing. | F 164 | (continued)<br>Nursing staff will be reinserviced on bib use on 9/18/86. | 9/30/86 |
| F-165<br>F-163 | Monthly wts. ordered are not recorded for each month — Examples:<br>R980 admitted 5/15/85 — no wts. on chart except dietary note of 98# for May.<br>R505 R3 wt. May - 120# June 118# July 106# — no wt. recorded for August | F 165<br>F 163 | Weights for September started 9/1/86 and will be completed prior to the end of the month. Weights will be taken monthly, and recorded as will be monitored by the D.O.N. and A.D.O.N. | 9/30/86 |

| | | |
|---|---|---|
| VIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| William Calliari | Agent of Oxford Lane | 9/15/86 |

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RM HCFA-2567 (10-84)

HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB No. [illegible]

## MENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

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| 163<br>1124 f | not all residents are provided with the amount of food and fluid on a daily basis to maintain their appropriate minimum average weight. Residents' food and fluid intake is not assessed, a percentile determination is not recorded or documented, for residents who are underweight, confused, and incapable of feeding themselves. Res # 694 whose diagnosis is dysphagia, OBS, S/P pneumonia, S/P Ⓛ CVA c̄ hemiplegia, S/P mi'l infarct, dementia & dehydration, does not have weight on medical record nor is there any reference to his extremely emaciated condition. Resident was weighed on request of surveyors, and the weight registered was 66 pounds. Resident is extremely emaciated and dehydrated. | F 163<br>405.1124 (f) | *Meal monitoring form documenting residents intake of food and fluids on a percentile basis will be utilized starting 9/30/86.<br>*Patients diets will be reassessed by the Food Service Supervisor to determine if appropriate diet prescription is being used. Nursing will be advised of results, with follow through by Food Service Supervisor. This will be done by the Food Service Supervisor and Dietary Coordinator, to be completed by 10/8/86.<br>*The Food Service Supervisor will assess nutritional status and work with nursing services and the physician to provide adequate food and fluids for the resident to reach and maintain the ideal body weight and proper hydration status. The assessment will be complete by 10/8/86.<br>*Resident #694 was discharged to the hospital for evaluation and treatment on September 15, 1986. Weights will be recorded monthly on the weight sheet and called to the attention of the physician and Dietary Supervisor for variance of 5 pounds or more. Nursing notes will be more inclusive and descriptive of the patient's condition. Nurses will be instructed in proper charting at the inservice of 9/26/86. The DON, ADON, and Med. Records consultant will monitor and evaluate these patients. | 9/30/86<br>10/8/86<br>10/8/86<br>9/26/86 |

ROVIDER REPRESENTATIVE'S SIGNATURE: William Calliari

TITLE: Agent of Oxford

(X6) DATE: 9/15/86 9/30

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AND HUMAN SERVICES
ADMINISTRATION

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(X1) PROVIDER NUMBER: 14-5375
(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______
(X3) DATE SURVEY COMPLETED: 9/15/86

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center
STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane Naperville, Ill. 60565

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| 221<br>5.1128<br>.1010 k | Signed and dated reports of clinical laboratory, X-ray and other diagnostic services are not always filed with the residents' medical records as evidenced by the following: Res # 078-R3 has no Dilantin level on chart for July. Last level in dated 5-29-86. Res # 943 - no culture and sensitivity of oozing wound on medical record. Res # 846 - Physician ordered Digoxin level on 7-10-86. No lab report in medical record. | F 221<br>405. 1128 | A new lab was started on 9/1/86. All Doctor's orders have been checked and charts reviewed for appropriateness of lab week ending 9/5/86. Lab, X-Ray, and Diagnostic services will be filed with the resident's record. The Medical Records consultant will train the Medical Records Designee on proper filing of records. The DON will instruct the floor nurses on the proper method of calling in diagnostic reports to doctors. The DON and ADON will monitor. Medical Records Consultant will monitor. | 9/30/86 |

PROVIDER REPRESENTATIVE'S SIGNATURE: William Calliari
TITLE: Agent of Oxford Lane
(X6) DATE: 9/15/86

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REGIONAL OFFICE

If continuation sheet Page __ of __

HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB No.

## MENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

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| 22<br>1124<br>) | Infection control techniques are not always properly carried out in the provision of care to each resident as evidenced by the following: Soiled, uncovered urinal next to water pitcher in Room 242² at 10:56 am on 9-9-86. Bedside table drawers were in dire need of cleaning. Stainless steel pan with cover, containing liquid with a film on it, and substance resembling sputum found in clean utility room on 2nd floor at 10:05 am on 9-9-86. Dentures, uppers and lowers, were in a rubber glove covered with Talcum powder, and a wet substance.<br>(continued) | F 122<br>405.<br>1124 | Infection control will be properly maintained. The following examples will be included in the next Infection control meeting, as well as in an inservice held on 9/16/86 and repeated on 9/18/86, and reinserviced as necessary:<br>1. Proper care of urinals<br>2. Cleaning of bedside drawers.<br>3. Proper cleansing of utensils and water pitchers, and use of clean and soiled utility rooms.<br>4. Core and storage of dentures. This need will be marked on the Kardex. Dentures will be marked.<br>5. Care of Foley bags to avoid infection.<br>6. Disposal of wet diapers and clothing.<br>7. Proper clean-up of incontinent patients.<br>8. Proper care of Decubitus.<br>9. Cleaning shower stall between showers<br>10. Immediate clean up of feces.<br>11. Cleaning of shaver between shaves<br>Floor nurse and DON and ADON will monitor. | 9/30/86 |
| | | | Inservice for housekeeping to include cleaning of bedrails, floors, and privacy curtains, and toilets has been scheduled.<br>The Housekeeping supervisor will monitor. | 9/30/86 |

PROVIDER REPRESENTATIVE'S SIGNATURE: William Calliari

TITLE: Agent of Oxford Lane

(X6) DATE: 9/15/86

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AND HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB NO. [illegible]

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING ________
B. WING ________

(X3) DATE SURVEY COMPLETED: 9-15-86

NAME OF PROVIDER OR SUPPLIER: Offutt Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Offutt Lane, Naperville, Ill. 60565

| PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.) | (X5) COMPLETION DATE |
|---|---|---|---|---|
|  | (Continued) |  |  |  |
| 122<br>1124 | Foley bag with urine in it, uncapped, in bedside table of Room 238¹. Resident #1080 dentures lying in drawer, not marked. Water pitcher 1/3 full, with a film on the water. Room 225¹ Wet diapers and clothing in wastebasket. Dried-brown smeared material on wash-basin and toilet. No cloth or paper towels observed in any bathrooms. Room 227² Dried feces on bedrail and floor. Dried brown material on privacy curtain Room 242¹. Room 238 Feces over wash basin, toilet cover & bowl & floor in (Continued) |  |  |  |

APPROVED BY STATE CERTIFYING AGENCY ☐
DISAPPROVED BY STATE CERTIFYING AGENCY ☐
(INITIALS)
DATE
PROVIDER REPRESENTATIVE'S SIGNATURE
(X6) DATE

APPROVED BY DHHS REGIONAL OFFICE ☐
DISAPPROVED BY DHHS REGIONAL OFFICE ☐
MEDICAID ONLY FACILITIES REQUIRE
(X) RESPONSE IN THIS BLOCK.)
REVIEWED BY (INITIALS)
DATE
TITLE

4 of 30

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

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FORM APPROVED
OMB NO. 0938-0391

## …ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING ____
B. WING ____

(X3) DATE SURVEY COMPLETED: 9-15-86.

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 122<br>5,1124 | (Cont.)<br>washroom and floor in room, on 9-9-86 at 11:05 a.m. Room was re-visited several times up to 5:00 P.m. and still had not been cleaned. Res #980 - leg bag was on bedside table, 2 Foley bags with urine were unclipped and dripping urine into wash basin in drawer of bedside table. Room 225 - water pitcher on bedside table with a film on the water.<br>Room 242² - Res #694 was lying in bed, completely exposed, had an undressed decubitus on back, a 4-inch scraped area on left hip | | | |

| | | | | |
|---|---|---|---|---|
| APPROVED BY STATE CERTIFYING AGENCY ☐<br>DISAPPROVED BY STATE CERTIFYING AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | PROVIDER REPRESENTATIVE'S SIGNATURE | (X6) DATE |
| APPROVED BY DHHS REGIONAL OFFICE ☐<br>DISAPPROVED BY DHHS REGIONAL OFFICE ☐<br>MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.) | REVIEWED BY (INITIALS) | DATE | TITLE | |

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.)

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Form HCFA-2567 (11-80) (Formerly SSA-2567)    1. HCFA REGIONAL OFFICE

SERVICES
ADMINISTRATION

# EMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A BUILDING ______
B WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | (continued) | | | |
| F122 | and both areas were covered with dried feces. | | | |
| F1124 | The upper back, both hips and the coccyx were extremely reddened, two skin tears on the left upper arm, one in the left elbow area and a skin tear on the right hand. The decubitus on his back was washed with soap and water during the bath. Staff are not aware of condition of residents' back. Room [illegible]12$^{2}$ - Uncapped Dextrostix tube beside an uncovered feeding syringe. Inside drawer of bedside table was unclean, had dried | | | |
| | (continued) | | | |

APPROVED BY STATE CERTIFYING AGENCY ☐
DISAPPROVED BY STATE CERTIFYING AGENCY ☐
REVIEWED BY (INITIALS)
DATE

APPROVED BY DHHS REGIONAL OFFICE ☐
DISAPPROVED BY DHHS REGIONAL OFFICE (MEDICAID ONLY FACILITIES REQUIRE RESPONSE IN THIS BLOCK) ☐
REVIEWED BY (INITIALS)
DATE

PROVIDER REPRESENTATIVE'S SIGNATURE
(X6) DATE
TITLE

Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.)

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HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB NO. [illegible]

# TEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

OF PROVIDER OR SUPPLIER: [illegible] Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane [illegible]ville, Ill. 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | (Continued) | | | |
| 122 | spilled. A wash basin in need of | | | |
| 1124 | cleaning contained a dry soapy residue. | | | |
| | Room 212 - Bedside table had | | | |
| | brown line streaks on bottom of | | | |
| | drawer. An ADL orderly was observed | | | |
| | shaving 3 residents with an electric | | | |
| | shaver without cleaning the shaver | | | |
| | at any time between shaves. | | | |

APPROVED BY STATE CERTIFYING AGENCY ☐
DISAPPROVED BY STATE CERTIFYING AGENCY ☐
REVIEWED BY (INITIALS)
DATE

APPROVED BY DHHS REGIONAL OFFICE ☐
DISAPPROVED BY DHHS REGIONAL OFFICE (REGIONAL ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK) ☐
REVIEWED BY (INITIALS)
DATE

PROVIDER REPRESENTATIVE'S SIGNATURE
(X6) DATE
TITLE

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

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AND HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

## EMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

ME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville Ill 60565

| PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X4) COMPLETION DATE |
|---|---|---|---|---|
| 123<br>,1124 | Proper nursing and sanitary procedures and techniques are not used when medications and eyedrops are administered to residents. Nurse administered eyedrops to resident in dining room without washing hands before or after procedure; medication was placed in a residents' mouth without nurse washing hands before or after procedure. Nurse did not have hand wipes on med cart. 12:45 pm on 9-9-86 in 2nd floor dining room. (Eyedrops Res# 140, meds placed in residents' mouth, Res. # 145.) | F 123<br>405.<br>1124 | Nurses will be inserviced on 9/19/86 on the proper technique in instilling eye drops. Eye drops will be administered prior to med passing. An insevice to reinforce the importance of hand washing during the med pass has been scheduled. Correct handwashing procedure will be maintained by all staff. The A.D.O.N. and D.O.N. will monitor. Handi-wipes will be provided on all med carts for nurse's use when passing meds. A.D.O.N. and D.O.N. will monitor. | 10/15/86 |

OVIDER REPRESENTATIVE'S SIGNATURE: illiam Calliari

TITLE: Agent of Oxford Lane

(X6) DATE: 9/15/86

15 of 30

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See erse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to nued program participation.

HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

# .EMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ___
B. WING ___

(X3) DATE SURVEY COMPLETED: 9-15-86

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Home

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 156<br>.1124a)<br>158<br>1124e)<br>) | Residents do not always receive restorative nursing care as evidenced by: Res #952. Right leg brace had been applied too tightly, resident had a red, circumferential band around her leg, and complained of pain. Her Ⓡ arm brace was on her bedside table – was not being utilized. Res. # 1119 did not have her foot protector on when in bed. Res #952 Arm brace applied too tight a manner, cradled in a sling. Sling was tied in knot at nape of neck and was causing irritation. She was crying until brace was loosened and sling was retied appropriately. Res #131 Arm brace found on floor in bath and shower room.<br>(continued) | F 156<br>405.<br>1124<br>e)<br>F 158<br>405.<br>1124<br>e) | Resident's restorative care will be carried out daily. D.O.N. will hold an inservice for nursing staff on all shifts on:<br>1. Proper application and care of appliances.<br>2. Use and placement of handrolls<br>3. Those items to be checked on Kardex.<br>4. Positioning of resident in wheelchairs and beds every 2 hours.<br>5. Proper use of Poseys.<br>6. Proper positioning of Foleys.<br>O.T. will be notified by nursing of those residents in need of hanrolls and these will be obtained and applied.<br>Resident Care Coordinator and Director of Nursing will monitor. | 10/15/86 |

PROVIDER REPRESENTATIVE'S SIGNATURE: William Calliari

TITLE: Agent of Oxford Lane

(X6) DATE: 9/15/86

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* Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet Page ___ of ___

HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB NO. 68 0 0060

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____
B. WING ____

(X3) DATE SURVEY COMPLETED 9-15-86

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 156<br>158<br>11242 | (continued)<br>Residents are not always positioned in wheelchairs, nor turned or positioned in their beds, as evidenced by the following: Res# 995 - Res was in need of positioning, and posey was applied in a manner that restricted any movement at all; it was tied to the uppermost part of the chair and to the two handles. Res#980 - in need of positioning in wheelchair, and Foley bag was dragging on the floor. Res#952, Ⓡ leg positioned poorly, brace applied too tight on Ⓡ leg. When released, it showed a red constricted band around leg and it had caused decreased (continued) | | | |

| | | | | |
|---|---|---|---|---|
| APPROVED BY STATE CERTIFYING AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | PROVIDER REPRESENTATIVE'S SIGNATURE | (X6) DATE |
| DISAPPROVED BY STATE CERTIFYING AGENCY ☐ | | | | |
| APPROVED BY DHHS REGIONAL OFFICE ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | |
| DISAPPROVED BY DHHS REGIONAL OFFICE ☐<br>(MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.) | | | | |

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

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SERVICES
ATION

FORM APPROVED
OMB No. 0938-0391

## T OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED 9-15-86

OF PROVIDER OR SUPPLIER ford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE 1525 Oxford Lane Naperville, Ill 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 56<br>58<br>1124 | circulation and pain, resident was in tears. Others not positioned in wheelchairs were #1120, 532, 1079, 980. Residents in need of positioning in their beds were #078. He was not turned nor positioned q 2 hours as he was observed by surveyors at 8:50am, 11:30am, 12:25p.m and 4:00pm and was in the same supine position on 9-10-86. Others poorly positioned in their beds were #1122, #252, #995, #078, #432, #980 and #694.<br>Residents c contracted hands in need of handrolls were #694, both hands contracted, #1122 #1051 and #145 | | | |

| PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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SERVICES

FORM APPROVED
OMB No. 0938-0391

## ENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | | | |
|---|---|---|---|
| (X1) PROVIDER NUMBER<br>~~14-5395~~<br>14-5375 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING ______ | (X3) DATE SURVEY COMPLETED<br>9-15-86 | |
| NAME OF PROVIDER OR SUPPLIER<br>OXFORD LANE NURSING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1535 OXFORD LANE NAPERVILLE, IL 60565 | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 114<br>5 1124(c) | TREATMENTS, MEDICATIONS AND DIETS ARE NOT BEING GIVEN AS PRESCRIBED AS EVIDENCED BY THE FOLLOWING:<br>ON 9-10-86 SURVEYOR OBSERVED A SUPRAPUBIC DRESSING IN PLACE ON #514 DATED 9-5-86 RESIDENTS TREATMENT RECORD INDICATED IT WAS CHANGED AT 6AM ON 9-6-86 THROUGH 9-10-86<br>RES # 1119 WAS ORDER FOR A FOAM DONUT TO SACRUM AT ALL TIMES. NO DONUT WAS IN PLACE 9-9-86 THROUGH 9-11-86 RESIDENT WAS OBSERVED IN BED ON THE ABOVE DAYS<br>RES # 701 WAS OBSERVED IN THE DINING ROOM EATING OFF OF THREE DIFFERENT TRAYS WITHOUT INTERVENTION ON 9-10-86<br>THE TREATMENT BOOK ON FIRST FLOOR INDICATED TREATMENTS NOT DONE ON RES # 1084 9-9-86 @ 9pm<br>RES # 243 9-9-86 @ 6pm-9-10-86 AT 9am<br>RES # 080 9-9-86 @ 6pm<br>RES # 096 9-9-86 @ 6pm<br>RES # 1123 9-9-86 @ 6pm<br>RES # 426 9-9-86 @ 6pm<br>(Cont) | F 114<br>405.1124<br>(c) | Treatments, medications and diets will be given as prescribed. The DON will give an inservice to all nurses on proper method for the following:<br>1. Changeing and charting dressings and treatments.<br>2. Placement of supportive pillows, blocks, donuts, mattresses.<br>3. A nursing staff member will be in attendance in the dining room at all meals to monitor residents.<br>4. Insuring all residents receive meal trays.<br>5. Feeding of residents who need who need assistance in a timely manner.<br>6. Insuring residents receive and swallow their meds.<br>The DON and ADON will monitor in conjunction with the Administrator who will also monitor. | 10/15/86 |

| | | |
|---|---|---|
| PROVIDER REPRESENTATIVE'S SIGNATURE<br>William Calliari | TITLE<br>Agent for Oxford Lane | (X6) DATE<br>9/15/86 |

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* Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OMB No. [illegible]

# NT OF DEFICIENCIES AND PLAN OF CORRECTION

|  |  |  |  |
|---|---|---|---|
| (X1) PROVIDER NUMBER<br>14-~~5425~~ 5375 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ____<br>B. WING ____ | (X3) DATE SURVEY COMPLETED<br>9-15-86 | |
| PROVIDER OR SUPPLIER<br>Oxford Lane Nursing Center | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1525 Oxford Lane Naperville IL 60565 | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| on't)<br>-114<br>s.1124(c) | RES # 958 DID NOT RECIEVE HER LUNCHTRAY ON 9-12-86 - THIS WAS REPORTED TO THE SURVEYOR<br>RES # 1122 WAS NOT FED BREAKFAST ON 9-11-86 AND AT 1 PM STILL HAD NOT BEEN FED ALTHOUGH THIS HAD BEEN REPORTED TO NURSING STAFF AT 11 30 AM.<br>1 ORANGE CAPSULE AND ONE BLUE TABLET WERE FOUND ON THE FLOOR OF ROOM 298 BY SURVEYOR<br>1 RED CAPSULE WAS FOUND ON THE FLOOR OF THE SECOND FLOOR DINING ROOM<br>1 RED CAPSULE WAS FOUND ON THE CLOTHING OF RES # 995<br>THESE WERE ALL FOUND ON 9-9-86 AT 1 PM APPRIXIMATELY. BY SURVEYORS | | | |
| 115<br>1124(c) | RESIDENTS ARE NOT RECIEVING DAILY PERSONAL HYGENE AS NEEDED AS EVIDENCED BY THE FOLLOWING:<br>RES # 993 DID NOT HAVE ANY SOCKS, UNDERWEAR OR GROOMING ITEMS IN HER BEDSIDE STAND FROM 9-9-86 THROUGH 9-13-86. ON 9-11-86 THE<br>(CONT) | F 115<br>405.1124<br>(c) | All residents will receive daily personal care and grooming. Those who do not have socks, shoes, or underwear will receive them through purchase or donations. Nexessary grooming supplies (soap, shampoo, mouth care) will be provided. Lotion for skin care will be available for those who need it. A new bath schedule is posted for two times weekly and prn baths or showers which aides must initial. Floor nurses will make sure aides administer them. Nurses will check Foleys for leakage and replace or remove prn.<br>(continued on next page) | 10/15/86 |

| PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| William Calliari | Agent of Oxford Lane | 9/15/86 |

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM HCFA-2567 (10-84)

HCFA REGIONAL OFFICE

If continuation sheet Page ___ of ___

HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | | | |
|---|---|---|---|
| (X1) PROVIDER NUMBER<br>14-~~5405~~ 5375 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING ______ | (X3) DATE SURVEY COMPLETED<br>9-15-86 | |
| NAME OF PROVIDER OR SUPPLIER<br>Oxford Lane Nursing Center | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1525 Oxford Lane Naperville IL 60565 | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| N°7<br>- 115<br>1124(C | NURSES AIDE CONFIRMED THAT SHE HAD NO GROOMING ITEMS TO USE FOR THE RESIDENTS OR CLOTHING TO LAUNDER.<br>RES # 1122, RES # 943 AND RES # 532 WERE OBSERVED WITH DRY FLAKY SKIN ON THEIR LEGS.<br>RES # 804 WAS OBSERVED WEARING THE SAME CLOTHING FOR THREE DAYS. THE PANTS HAD A BROKEN ZIPPER AND MANY OLD FOOD STAINS.<br>RES # 930, 804, 145, 432, 1058 WERE OBSERVED ON 9-9-86 WITHOUT SHOES. RES # 993 AND # 1150 WERE OBSERVED WITHOUT SHOES OR SOCKS. IN AN OVERVIEW OF RESIDENTS IN THE DINING ROOM ON 9-9-86 15 OF 34 RESIDENTS DID NOT HAVE ANY SHOES ON.<br>URINE, BODY AND FECES ODORS WERE NOTED ON THE FOLLOWING RESIDENTS # 694 # 943 # 1079 # 993 # 586 # 974 # 1028 (Cont) | F 115<br>405.1124 (c) | Admissions have been curtailed and no skilled or Medicare residents will be admitted until staff is stabilized.<br>Administrator and Admissions Director will monitor. | 10/15/86 |

| | | |
|---|---|---|
| PROVIDER REPRESENTATIVE'S SIGNATURE<br>William Calliari | TITLE<br>Agent of Oxford Lane | (X6) DATE<br>9/15/86 |

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21/673

FORM HCFA-2567 (10-84)

HCFA REGIONAL OFFICE

If continuation sheet Page ___ of ___

AND HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

## MENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-~~5405~~ 5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____
B. WING ____

(X3) DATE SURVEY COMPLETED: 9-15-86

OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane Naperville IL 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 115<br>113.16(c) | #701 #1058. Residents #1122 and #1028 were observed lying in wet beds and both of these residents had Foley catheters in place. | | | |
| 116<br>117<br>1124(c) | Residents are not receiving care necessary to prevent skin breakdown as evidenced by the following.<br>Res #694 was observed with a very reddened area on the coccyx area, an open lesion above the coccyx area, ~~a sor~~ an abrasion on the left hip 4" in length, skin tears on the upper left arm, right hand and L. elbow area. Nursing staff had no knowledge of any skin breakdown on the resident.<br>Res #1119 was observed to have a Stage II decubitus on (CON'T) | F 116<br>F 117<br>405.1124(c) | Residents will be monitored for skin breakdown by use of decubitus program (attached) which includes risk assessment, treatments and use of special mattresses and assessment sheets. Skin checks will be performed frequently by treatment nurses for bedfast and wheelchair patients to reduce the chance of error in reporting developing decubiti. Assessments will be accurate. An inservice covering the above will be held by 9/26/86 by the D.O.N. and will be monitored by her. | 9/26/86 |

PROVIDER REPRESENTATIVE'S SIGNATURE: William Calliari

TITLE: Agent of Oxford Lane

(X6) DATE: 9/15/86

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See verse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to ntinued program participation.

HCFA 2567 (10-84)

HCFA REGIONAL OFFICE

If continuation sheet Page ___ of ___

FORM APPROVED
OMB No. 0938-0391

ADMINISTRATION

ENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375 ~~5408~~

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9-12-86 ~~4/30/86~~

OF PROVIDER OR SUPPLIER: xford Lane Nursing Home, LTD

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 South Oxford Lane. Naperville, IL. 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| .16<br>17<br>.248(1) | ~~THE~~ COCCYX AREA. THE DONUT CUSHION ORDERED BY THE PHYSICIAN WAS NOT BEING USED AND THIS DECUBITUS HAD NOT BEEN ADDRESSED BY NURSING STAFF IN TREATMENT BOOK OF RECORD.<br>RES # 078 R3 WAS OBSERVED BY SURVEYOR ON HIS BACK ON 9-10-86 @ 8 50AM 11.30AM 12 25pm AND 4pm. THIS RESIDENT WAS NEVER OBSERVED IN A DIFFERENT POSITION DURING SURVEY 9-9-86 through 9-11-86<br>RES # 980 HAS A PHYSICIANS ORDER | | | |
| 37 | FOR AN EGG CRATE MATTRESS. THIS WAS NOT OBSERVED ON THE RESIDENTS BED | F 237 | Residents with orders for special mattresses will be reviewed by DON to ensure that physician's orders are followed. The DON and ADON will monitor. | 10/15/86 |
| 239<br>40<br>.248(1) | RESIDENTS CARE PLANS ARE NOT UPDATED IN A TIMELY MANNER AND DO NOT REFLECT ALL THE RESIDENTS NEEDS AS EVIDENCED BY RES # 952 LAST REVIEW 3-28-86<br># 980 LAST REVIEW 3-28-86<br>(CONT) | F 239<br>F 240<br>405.1124 (d) | Resident care plans will be accurate and timely. An RN Resident Care Coordinator has been designated to insure this and has started update. A care plan schedule has been posted. An inservice on care plans will be held by the Resident Care Coordinator for all nursing staff. DON will monitor. | 10/15/86 |

VIDER REPRESENTATIVE'S SIGNATURE: llam Calliari

TITLE: Agent of Oxford Lane

(X6) DATE: 9/15/86

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y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See rse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to nued program participation.

m HCFA-2567 (10-84)

HCFA REGIONAL OFFICE

AND HUMAN SERVICES
NG ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

## MENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-~~5405~~ 5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________
B. WING ____________

(X3) DATE SURVEY COMPLETED: 9-15-86

E OF PROVIDER OR SUPPLIER: ford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane Naperville IL 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 43 | TRAINED IN FIRE AND EVACUATION | | | |
| 44 | PLAN FOR THIS FACILITY. | | | |
| 45 | STAFF WAS OBSERVED NOT USING | | | |
| | ASEPTIC TECHNIQUE IN CARING FOR | | | |
| | RES #694 | | | |
| 25 | URINE LEG BAGS WERE OBSERVED NOT | | | |
| 1124 | RINSED OUT AND IMPROPERLY STORED | | | |
| | IN BEDSIDE TABLES | | | |
| | REFERENCE TO 3-122 | | | |
| | RESIDENTS WERE OBSERVED | | | |
| | EXPOSED AND ~~WERE~~ PRIVACY WAS NOT | | | |
| | PROTECTED - REFERENCE TO 3-76 | | | |
| | A FULL BEDPAN WAS OBSERVED | | | |
| | BESIDE A RESIDENTS BREAKFAST | | | |
| | TRAY - REFERENCE TO 3-75 | | | |

IDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See se for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to ued program participation.

HCFA-2567 (10-84)

AND HUMAN SERVICES
ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

## EMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-~~5105~~ 5375
(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______
(X3) DATE SURVEY COMPLETED: 9-15-86

OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Care
STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 So Oxford Lane Naperville Il 60565

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 262<br>1132(c)<br>)<br>[illegible]<br>63<br>1124<br>) | Nurses notes do not describe the residents response to nursing services provided. Examples of this are. Res # 694, last N/N entry was 8-26-86. There were only two entries in the nurses notes for the months of June through August. The Resident is in a fetal position, has bilateral hand contractures, does not communicate and is emaciated weighing only 66 pounds. This resident requires total care.<br>Res # 078 nurses notes do not identify lesions, there are no descriptions given, they speak only of dressing changes and do not state what response is to nursing care. The residents bleeding sores are not described and skin of the legs and feet are not mentioned. | F 262<br>405.<br>1132<br>(c) | Nurses' notes will describe response to to nursing interventions. Nurses' notes will be written at least weekly and prn and describe patient's condition accurately. An inservice will be held by the DON and by Alden Managment by 9/26/86 | 9/26/86 |
| | | F 262<br>Reference<br>F 163<br>405.<br>1124 | A record of resident's bowel movements will be recorded on a form developed for this by nursing staff.<br>The DON and ADON will monitor | 10/15/86 |

OVIDER REPRESENTATIVE'S SIGNATURE: William Calliari
TITLE: Agent of Oxford Lane
(X6) DATE: 9/15/86

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26/30

orm HCFA 2567 (10-84)

HCFA REGIONAL OFFICE

ADMINISTRATION

FORM APPROVED
OMB No. 0938-0391

## MENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-~~5405~~ 3375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________
B. WING ________

(X3) DATE SURVEY COMPLETED: 9-15-86

OF PROVIDER OR SUPPLIER: OXFORD LANE NURSING Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 So Oxford Lane Naperville Il 60565

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 262<br>1132<br>163<br>1124 | Residents bowel movements are not being recorded or documented in the residents record. Examples of this are: Res # 1128 Res # 766 Res # 1122 and Res # 532 | | | |

OVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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RM HCFA-2567 (10-84)

HCFA REGIONAL OFFICE

AND HUMAN SERVICES
NG ADMINISTRATION

FORM APPROVED

# ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A BUILDING ______
B WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

| (X4) PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F286<br>F289<br>05.1134(e) | Not all residents have comfortable and suitable beds to meet their needs, as some beds are not long enough to accommodate residents' feet which hang over the end of the bed. Examples are: Residents #s 210, 514, 943, 137, and #078. | F-286<br>F 289<br>405.1134 e) | Current mattresses are 75". 80" mattresses were ordered on 9/17/86 from made rite bedding. Delivery promised week of 9/22/86. These will be provided as needed. | 9/26/86 |

| | | REVIEWED BY (INITIALS) | DATE | |
|---|---|---|---|---|
| PPROVED BY STATE CERTIFYING AGENCY | ☐ | | | PROVIDER REPRESENTATIVE'S SIGNATURE: William Calliari |
| SAPPROVED BY STATE CERTIFYING AGENCY | ☐ | | | X6 DATE: 9/15/86 |
| PPROVED BY DHHS REGIONAL OFFICE | ☐ | | | TITLE: Agent of Oxford Lane |
| SAPPROVED BY DHHS REGIONAL OFFICE<br>EDICAID ONLY FACILITIES REQUIRE<br>O RESPONSE IN THIS BLOCK) | ☐ | | | |

Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting roviding it is determined that other safeguards provide sufficient protection to the patients. See reverse for further instructions.)

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AND HUMAN SERVICES
ADMINISTRATION

FORM APPROVED

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

NAME OF PROVIDER OR SUPPLIER: Oxford Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Oxford Lane, Naperville, Ill. 60565

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 7 76<br>5.1121<br>7245<br>1121h | Residents are not always given privacy and protection during treatments and care of personal needs as evidenced by the following: Res. #694 was observed exposed; door to room was open, and privacy curtains were not drawn. Surveyors observed dried feces on residents' back and on his bed. Bathing equipment, such as a wash basin was apparent, but aide was not in sight. 11:10 am 9-9-86 Res #995 was observed exposed (continued) | F 76<br>405.1121<br>F 245<br>405.1121 h) | Residents will be given privacy and protection during treatments and care of personal needs. An inservice was held on the use of privacy curtains on 9/16/86 and will be repeated on 9/18/86. An inservice on proper application of restraints will be held by 9/26/86<br>All inservices will be repeated and monitored by administrative staff as needed on a permanent basis to ensure ongoing understanding and compliance. Staff will be disciplined and/or terminated for non-compliance. | 10/15/86 |

| | | | |
|---|---|---|---|
| APPROVED BY STATE CERTIFYING AGENCY ☐<br>DISAPPROVED BY STATE CERTIFYING AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | PROVIDER REPRESENTATIVE'S SIGNATURE: William Calliari |
| APPROVED BY DHHS REGIONAL OFFICE ☐<br>DISAPPROVED BY DHHS REGIONAL OFFICE (MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK) ☐ | REVIEWED BY (INITIALS) | DATE | TITLE: Agent of Oxford Lane |

(X6) DATE: 9/15/86

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.)

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Form HCFA-2567 (11-83)

ADMINISTRATION

OMB NO.

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 14-5375

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING ______
B. WING ______

(X3) DATE SURVEY COMPLETED: 9-15-86

NAME OF PROVIDER OR SUPPLIER: Offord Lane Nursing Center

STREET ADDRESS, CITY, STATE, ZIP CODE: 1525 Offord Lane, Naperville Ill 60565

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| 76<br>5.1121<br>245<br>5.1121 R | (Continued)<br>on two different occasions in her bed – 9-9-86 at 3:35 Pm, and on 9-10-86 at 4:15 Pm. Res. #061 was observed exposed at 10:55 a.m. on 9-9-86 with no undergarments on; she was scrunched up at the head of her bed, restricted by her posey which was tangled up. | | | |

APPROVED BY STATE CERTIFYING AGENCY ☐
DISAPPROVED BY STATE CERTIFYING AGENCY ☐
REVIEWED BY (INITIALS)
DATE
PROVIDER REPRESENTATIVE'S SIGNATURE
(X6) DATE

APPROVED BY DHHS REGIONAL OFFICE ☐
DISAPPROVED BY DHHS REGIONAL OFFICE ☐
(MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)
REVIEWED BY (INITIALS)
DATE
TITLE

30 of 30

*Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

Form HCFA-2567 (11-80) (Formerly SSA-2567)    1. HCFA REGIONAL OFFICE    Page ___ of ___

LONG TERM CARE
management
NEWS & FINANCIAL INFORMATION FOR HEALTH CARE MANAGERS
May 14, 1987/Vol. 16/No. 10

## IL Home Decertified In March Won State "Excellence" Award

Charges of horridly poor care at an Illinois nursing home that has been heralded by that state were heard this week by the House Commerce Health Subcommittee.

One patient at Oxford Lane Nursing Home in Naperville was handcuffed and another forced to spend the night in a room with the corpse of a dead patient, says Sue Mettel, who heads a group representing residents and their families. Other results of poor management cited by Mettel included the amputation of a patient's leg because of complications from an infected bedsore, and the deaths of two patients from dehydration.

The federal government terminated the 206-bed proprietary facility's right to government reimbursement for skilled nursing care on Mar. 15, 1987. The facility has made "major" staff changes and is confident its skilled beds will be recertified, says Steve Molo, attorney for Oxford Lane.

Beginning in July 1986, Oxford Lane got bonus payments from Illinois' much-heralded Quality Incentive Program (QUIP), which rewards nursing homes for excellence in six categories, including structure and living environment and quality of nursing care (LTCM 4-2).

In this case, payments acknowledged Oxford Lane's resident activity and community integration work, not its nursing care, says Illinois long term care bureau chief Connie Cheren. As soon as the state inspectors notified QUIP of Oxford Lane's deficiencies (Dec. 14, 1986), bonus payments were stopped, she says.

"They [nursing homes] get paid for what they are improving. We have never said that the 600 nursing homes that get QUIP are the best homes. QUIP homes are those that are trying" to upgrade care in the program's six categories, Cheren said. Cheren says the Oxford Lane case "absolutely" does not tarnish QUIP's image.

Mr. **Waxman**. Thank you very much.

You know, it must take a lot of courage for you to come here and tell us this story. Your mother is still in that nursing home, isn't she?

Ms. **Mettel**. Yes, she is.

Mr. **Waxman**. When you found out about all these problems, did you consider taking her out and moving to another facility?

Ms. **Mettel**. Yes, I did. That was the first thing that I decided to do. It was very difficult to place her in this facility to begin with. She's on public aid, and it was very difficult. There are 18 nursing homes in Du Page County, and out of those 18, only, I guess, 12 take public aid patients, and all of them have a 1- to 2-year waiting list. And so it's very difficult, considering that Oxford Lane has a total of 170 residents, and out of that, 150 are on public aid. And with the thought of them—they were decertified for skilled care, and several of the residents had to move. One had to go to Rockford, which is 50 miles west of us, which is very difficult to go visit someone, because there are no facilities in our area that will take public aid patients.

Mr. **Waxman**. So the options are very, very limited for someone who is on the Medicaid program.

Ms. **Mettel**. Yes, yes.

Mr. **Waxman**. Why didn't the State act to improve the quality of care?

Ms. **Mettel**. That's one of our questions, and that was one of the reasons why we did file suit. We had hoped that we would be able to put them on the stand, so we could ask them the very same question.

They have been documented as far back as 1984 as having serious staffing problems, and they have continually been on the Illinois Department of Health's violator list. It's a quarterly list, and they have been on it in 1984, 1985, and 1986 for staff shortages.

And that was our question: Why is the governing agent that's supposed to protect us and help us in this situation—why do they continually allow something like this to go on?

We never did get an answer to that, and I don't have an answer to that myself.

Mr. **Waxman**. Ms. Fitzpatrick, why was your mother initially placed at Belmont Nursing Home?

Ms. **Fitzpatrick**. We were at Vanderbilt, and as I said, she had been going there for years, and when she left home, we had admitted her to Vanderbilt, and she had been there like 2 weeks. And they told us that we needed to place her in one.

We visited around, and it was hard to get in because we didn't have all the money, and she would have to be placed on Medicaid. And there was a place available there. We went and looked, and also the doctors had started a geriatric program at Vanderbilt to Belmont, and that was out—you know, I thought, well, that should be a good one, you know; we're having our physicians go there, so that was our intent.

Mr. **Waxman**. And why was she forced to stay there after her condition began to deteriorate?

Ms. **Fitzpatrick**. I had no choice. She had a staph infection. No other place would take her. Her problems were too serious.

Mr. **Waxman**. And according to your statement, this nursing home remains in the Medicaid program, despite the poor treatment your mother and other residents received.

What has the State done about it, and why hasn't the quality of care at that home improved?

Ms. **Fitzpatrick**. That's what I want to know also, because they've had all the violations. In fact, they are closed for admissions as of right now.

On our board for licensing, there is no consumer advocate. There are three nursing home administrators. One administrator is a former nursing home owner, and he has also—his home was closed for admissions also.

They went in. They had—in fact, they had a lady there that was monitoring Belmont. This was 2 years ago when all this happened to me. They'd taken her out. We don't know. We'd like that question answered also.

Mr. **Waxman**. Let me call on my colleagues to see if they have some questions of you.

Mr. Whittaker.

Mr. **Whittaker**. No questions.

Mr. **Waxman**. Mr. Wyden.

Mr. **Wyden**.

I commend both of you for your fine statements. What advice or counsel would you two have for others with parents in or about to enter a nursing home?

You both have been through very unfortunate experiences, and I would be interested in knowing what thoughts you have for others who might be in your shoes.

Ms. **Mettel**. Well, we have addressed that in our group, and I think it's very important that people be educated as to what the residents' legal rights are. You know, it's—they have the upper hand in the situation, and when they tell you, "You're going to have to move your patient because we no longer take Medicaid," you know, you say, "Okay, fine," and you do it. You have to find out what your rights are and to not let them, you know, put you in a position like that.

And it's also a good idea if each facility would have a family group, as ours does. I know that they may not be as active, but it's really good to be able to talk to someone who has the same common problems that you do.

Mr. **Wyden**. Ms. Fitzpatrick, what counsel would you have for others with parents in or about to enter a nursing home?

Ms. **Fitzpatrick**. I would find out their legal rights and also your legal rights as to what you can do when situations occur.

Also when you go to visit the nursing home on your initial visit, don't just go to where they're walking around. Be sure you go to the skilled care part of the building. Check with the patients there; check with them and look at them. If necessary, pull down those covers and see how their bodies are. If there's any family members there, talk with them, just communicate with people, and please don't let them intimidate you. That's what happened with me.

Mr. **Wyden**. The only other question I had was based on an experience I had when I was on the State Board that licensed the administrators. When the complaint was filed, what did the State do?

Did they in any way tip off the facility, or did they just fail to follow it up altogether. What happened when complaints were filed with the State?

You've already made it clear that they didn't do enough.

But maybe you could start, Ms. Mettel. What exactly did the State do?

Ms. **Mettel**. Well, at our particular nursing home, one of the members of the staff had worked with the Public health department as a surveyor, so she had a lot of friends in the Health Department. And whenever they were going to pull an inspection, they would call and talk to Mary, and she knew about it ahead of time. And we ultimately found out what was going on, because they would pull in staff from some of their other nursing homes. The same people who own this one own four other nursing homes in the area.

So they would pull in other staff from the other nursing homes to make it look like they had a full complement of staff.

But other than that, I don't really know. They also did not treat it with confidentiality. I know when we would complain about something, when a formal complaint had been issued, it was just a matter of hours before the whole nursing home knew about it and could tell you exactly, you know, which person had initiated it.

Mr. **Wyden**. Anything you wanted to add on that, Ms. Fitzpatrick?

Ms. **Fitzpatrick**. The nursing administrator at the home that my mother was in had also worked for the State, going out and inspecting, and she always knew when they were coming out. And they also were supposed to keep confidentiality, and when my complaint—when I was giving my complaint, you could see my name and also my mother's name, so evidently it wasn't treated that way.

Mr. **Wyden**. Thank you, Mr. Chairman.

Mr. **Waxman**. Mr. Sikorski, any questions?

Mr. **Sikorski**. Thank you, Mr. Chairman.

I, too, want to thank you. I found that working as an orderly in a nursing home and then later on with the Board on Aging in the State legislature that the advocacy program—family advocates and advocates for residents—are absolutely essential to make sure that the system works. The pushers and pinchers and pullers in the process—sometimes they can be a pain in the neck for the legislator, or the regulator or the nurse, or the administrator, but it's one of those things that's absolutely essential if we're going to have a system that's sensitive to the human needs of the human beings involved.

So thank you for being advocates.

I have some questions. Maybe you know, the per diem paid in the Medicaid program for your—was it your mother?

Ms. **Mettel**. Yes.

Mr. **Sikorski**. For your mother's care?

Ms. **Mettel**. Is there a per diem?

Mr. **Sikorski**. Yes. What is the per diem?

Ms. **Mettel**. I'm sorry. I don't know.

Mr. **Sikorski**. You don't know.

Ms. **Mettel**. No.

Mr. **Sikorski**. Do you know what it is in Illinois generally?

Ms. **Mettel**. No.

Mr. **Sikorski**. Do you know, Ms. Fitzpatrick, in Tennessee?

Ms. **Fitzpatrick**. At the time we were there, I was told it was $32 or $33 a day.

Mr. **Sikorski**. And this is in the last year?

Ms. **Fitzpatrick**. Three years ago.

Mr. **Sikorski**. Three years ago. So it's probably—may have changed since then.

In my opening statement, talking about money, unfortunately there is money—a money factor in this. You've got to pay for a certain level of care. But as I understand it, there was a level of care, say the skilled level, in your mother's case and your mother's case, too, I think, and so many nursing hours were to be supplied for that level of care, and the per diem was to pay for that, but those hours weren't being supplied; is that correct?

Ms. **Mettel**. Correct. But they still were getting paid for it.

Mr. **Sikorski**. Has anyone taken fraud action? Has anyone attempted to reclaim from the owners of that facility the payments for services that weren't rendered?

Ms. **Mettel**. As I understand it, that was one of the things that Prairie State Legal Services was going to look into.

Mr. **Sikorski**. OK.

Ms. **Mettel**. That was something that came out because of our situation. That became known, and they said they were going to look into that, plus discrimination suits against Public Aid patients in Du Page County.

Mr. **Sikorski**. Was the nursing home in your situation owned by local small chain?

Ms. **Mettel**. Yes.

Mr. **Sikorski**. Not affiliated with a larger chain?

Ms. **Mettel**. I don't believe so, no.

Mr. **Sikorski**. And the owners were local? You knew them?

Ms. **Mettel**. Yes. We did have trouble pinpointing who the owners were, and even when we filed suit, we still did not know who exactly who they were.

Mr. **Sikorski**. Do you know now?

Ms. **Mettel**. Not all of them.

Mr. **Sikorski**. But doesn't the State know? The State should know that.

Ms. **Mettel**. I hope someone knows.

Mr. **Sikorski**. But where in the hell are the State legislators in this situation? How come there aren't any local or State hearings? Did they have hearings in Illinois after you raised your issue?

Ms. **Mettel**. No, sir.

Mr. **Sikorski**. Where are the State and local authorities?

Ms. **Mettel**. I don't know.

Mr. **Sikorski**. Have you talked to your local State senator and representative?

Ms. **Mettel**. We did have a local representative that we had come talk to us, and she—her advice to us was to go to the press and tell the press what was going on. But we didn't feel comfortable doing that. We didn't feel we had enough facts behind us to substantiate an action like that.

But I want to know, why didn't she tell us something about, you know, these different groups that are out there, like Illinois Citizens for Better Care? Why weren't we told about them or Prairie State Legal Services or someone who could have helped us?

Instead, we were just left to flounder and try to figure out what to do on our own.

Mr. **Sikorski**. Maybe our State is different, but I didn't think it was that different. I used to speak to the National Conference of State Legislators and the Human Resources Division about these issues, and I didn't think Minnesota was that far ahead. But, you know, there are basic things like a bill of Rights for residents and Residents Advocacy Councils. There is extensive interplay between the providers and the professional staff and the residents and the legislators.

But in Tennessee, where are the legislators there? Did you talk to them?

Ms. **Fitzpatrick**. In this past year, they passed legislation to impose civil penalties. How good that is going to be, I don't know. At the time, I didn't know anyone to talk to. Since then, I could find someone, but at that time, I didn't have anyone.

Mr. **Sikorski**. These are basically State programs federally funded. There are certain standards on both levels and there should be enforcement and oversight and it is really a State legislative function to a great extent. At least a major impact can be made at that level. They have been thus far silent in Illinois?

Ms. **Mettel**. We tried to work with our local Public Health Department, the regional supervisor. We were in contact with her for about 5 months, asking her what's going on, give us some direction, give us some help. We find out later on that the Springfield office didn't even know what she was doing. There was some type of a breakdown in communications between them.

Mr. **Sikorski**. Apparently the national regulations have been violated that are currently in existence, not even considering the new reforms that are being proposed. Assuming those reforms get adopted, there is still going to be a State and local enforcement mechanism and those State legislators better be heated up a little bit.

Thank you.

Mr. **Waxman**. Thank you, Mr. Sikorski. Mr. Walgren.

Mr. **Walgren**. No questions, Mr. Chairman.

Mr. **Waxman**. Mr. Bruce.

Mr. **Bruce**. No questions, Mr. Chairman.

Mr. **Waxman**. Mr. Dingell.

Mr. **Dingell**. I would ask unanimous consent that I be permitted to insert into the record a strong statement in support of the legislation. I wish to commend you for the hearings and the speedy way in which you are proceeding in this matter.

Mr. **Waxman**. Thank you very much. Without objection, the statement will be included in the record.

Mr. **Bruce**. Mr. Chairman, I would request my statement be submitted for the record.

Mr. **Waxman**. Without objection, the unanimous consent request to insert the opening statement by Mr. Bruce will be agreed to and that will be the order.

[The prepared statements of John D. Dingell and Terry L. Bruce follows:]

### STATEMENT OF HON. JOHN D. DINGELL

I am pleased to join my colleagues, Chairman Henry Waxman, and Senator Claude Pepper, and others at this hearing.

We are here today to address the need for legislation to improve the quality of care provided in Medicaid nursing homes.

Too often in the past we have met together to hear horror stories of the inadequacies of nursing home care: stories of neglect and abuse—both physical and mental—of our most frail and most vulnerable citizens. Today we will hear more.

But this hearing also marks a beginning, because we have now before us for consideration a new and very different piece of legislation.

H.R. 2270, the Medicaid Nursing Home Quality Care Amendments of 1987, is a major reorientation of the regulatory system, which will now focus upon the nursing home resident. This bill directs the regulatory system to look at the care being provided to residents, and the effects of that care on their wellbeing.

This does not mean that we no longer about the fire safety of buildings, or the cleanliness of the floors, or whether or not there are cockroaches, or the credentials of the nursing staff. These things are important, but when you are dealing with people these are not enough. We need a regulatory system that will ensure that any person requiring nursing home care can enter any certified nursing home and receive appropriate medical care, be treated with dignity, and enjoy continued civil and legal rights.

We also need to deal with the inability of the current regulatory system either to force substandard facilities to improve their performance or to eliminate them.

I believe that H.R. 2270 does all of these things.

It is appropriate and necessary for the Federal Government to be involved in the regulation of nursing homes for two reasons:

First, large sums of Federal money—mostly from Medicaid—go to pay nursing home costs. We must ensure that these funds are spent as well and as wisely as possible.

Second, we must protect the consumer—in this case the nursing home resident. We must ensure their safety, the adequacy of their care, and the protection of their rights. Nursing home residents are almost always dependent on medical care for a satisfactory quality of life.

Our past experience does not support an optimistic judgment about the effects of allowing the forces of the market place to be the primary influence over nursing home standards. The need for government protection is more critical because the ability of the average nursing home resident to be an active and discriminating consumer is usually very limited. Nursing home residents are often in poor physical and mental health, nursing home beds in many areas are in short supply, and most nursing home residents are not financially well-off.

The nursing home market is in fact two markets—a preferential one for those who can pay their own way, and a second, more restricted one, for those whose stays are paid by Medicaid.

Regulation is essential to protect these vulnerable consumers.

At this point however I must add my belief that while regulation is necessary, it is not on its own sufficient to guarantee high quality care. To achieve this goal we need involvement from management and staff, the community and the consumer groups.

I am pleased to see that many of these groups are here today to add their voice to this legislation. I thank them for their thoughtful participation. I am grateful to my colleague, Chairman Henry Waxman for having this hearing, and for the excellent work which his staff has contributed towards this bill. I look forward to working with all of you towards passage of a bill which will benefit a most deserving and important group of our citizens.

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### STATEMENT OF HON. TERRY L. BRUCE

Thank you Mr. Chairman. I would like to commend you and the Chairman of the Full Committee, Mr. Dingell, for your efforts in bringing forth this important legislation. There is a strong evidence that the quality of care and quality of life in nursing homes is not up to the standards that we demand for our senior citizens. Hearing up to the standards that we demand for our senior citizens. Hearings last year, and the Institute of Medicine's report has shown that more effecting government regulation can substantially improve the quality of care in nursing homes. I am very please that we are here today to discuss a new, stronger Federal role in regulating this industry.

In drafting H.R 2270, the subcommittee consulted essentially all interested parties. Naturally, there are some points of disagreement as is bound to happen with any genuine compromise. It is my intention to strongly support the bill and facilitate final passage of the legislation.

Thank you again, Mr. Chairman for bringing this legislation before the subcommittee.

Mr. WAXMAN. Thank you both very much. I think you have set the tone for us to look at this whole matter. People are involved, your parents, our parents, our elderly people in this country going into nursing homes. These nursing homes are getting Federal funds. The Medicaid program is run by the States. We expect if Federal dollars are going to be used, there be a minimum standard of care provided for these patients. It is a responsibility of the Federal Government as well as the State governments to see that quality care is provided.

I thank you very much for coming.

Our next panel consists of two analysts of nursing home policy. First is Dr. Anthony Robbins. Dr. Robbins has been involved with nursing home policy for several years at the Federal and State levels. He served as Health Commissioner for the State of Colorado during the initiation of the *Smith* case, the leading litigation on monitoring and enforcing nursing home quality. Dr. Robbins is also a consultant to the Energy and Commerce Committee on health issues. We all know him very well from that association.

Second is Mr. Bruce Vladeck, who is currently president of the United Hospital Fund of New York. Mr. Vladeck served as a member of the 1986 Institute of Medicine Nursing Home Reform Study Group and is the author of a major study of the nursing home industry titled "Unloving Care."

Thank you both for being with us today. We are looking forward to your testimony.

Dr. Robbins, we would like to start with you. Would you be sure the microphone is on.

## STATEMENTS OF ANTHONY ROBBINS, PROFESSOR, BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH; AND BRUCE C. VLADECK, PRESIDENT, UNITED HOSPITAL FUND OF NEW YORK

Mr. ROBBINS. Thank you, Mr. Chairman.

The history of the nursing home industry and its regulation is a relatively brief one in the United States. Only since the passage of the Medicaid and Medicare legislation in 1965 have nursing homes flourished in this country. From the beginning, Medicare provided time limited coverage for care in nursing homes, thus Medicaid became the dominant payment system for nursing home services.

It was the availability of nursing home coverage under Medicaid that led to the tremendous boom in nursing home resources in the United States. In the late 1960's, capital flooded into a bizarre collection of mansions, inns, hotels, rest homes, aged hospitals and boarding homes to convert them to nursing homes, the things we now know as skilled nursing facilities and intermediate care facilities.

Not surprisingly, the early concerns of State and Federal officials charged with protecting nursing home residents were for fire safety. Was there any way to make these building safe for handicapped and often bed ridden residents? Thus, the earliest inspection and enforcement systems were concerned with the physical structures. In the first years of Medicaid, the inspection and enforcement system evolved but the basic concept remained the same.

The question was whether the facility had the capacity to care for nursing home residents. Inspectors looked at the facility for fire safety, doors, exits, stairs, alarms, sprinklers, et cetera, and there were often waivers granted until physical improvements could be made. Inspectors tended to review a growing body of documents, policies, plans and accounts and inspectors reviewed the staffing, looking at the number of nurses and their credentials.

What they didn't do is look at what the nurses actually did for residents. Most important, with a system intended to evaluate the capabilities, the enforcement system rarely looked at what was happening to the residents themselves.

I will return to this point which is central to this reform legislation.

The last 20 years has seen a long line of nursing home scandals. The scandals have always raised the question of whether the United States and the State governments have the proper armamentarium to protect residents of nursing homes from operators who are willing to risk lives in the quest of profit.

In the early 1970's, a New York State Court made the regulators' dilemma very clear. It held that the State Health Department was not allowed to remove Medicaid recipients from an unsafe facility without a full administrative process, because the facility had a "property" interest in the residents. The Court said the nursing home owned the right to continue to collect from Medicaid.

During the same 20 years, three important developments have changed the situation. Consumer groups have come to the aid of nursing home residents. Some States have been creative and increased their ability to protect residents. The Federal Government, by sponsoring research, has learned how to reform the inspection and enforcement system so that it focuses on residents.

Let me deal with those three things.

Consumer activists including the Gray Panthers, the American Association of Retired Persons, and the National Citizens Coalition for Nursing Home Reform, are responsible for a vast change in public attitudes. Aided by an attentive press, these groups have convinced most Americans that there are serious problems in nursing homes. Obviously, this is invaluable as the committee goes about seeking legislative reform.

States have become increasingly concerned about nursing homes. For most States, the first concern is money. The elderly population is growing. Nursing home services are the most rapidly growing part of Medicaid and Medicaid is in most States the most rapidly growing part of the State budget. States have restrained the expansion of nursing homes. In most States, therefore, the number of nursing home beds per elderly citizen has declined, thus the residents have become older and sicker on average. This was documented in a General Accounting Office report prepared for this committee, I think about 3 years ago.

State governments concerned with nursing home enforcement have run head on into the Federal enforcement system. Because the Department of Health and Human Services establishes the Medicare rules and requires similar procedures for Medicaid, before the Federal Government will contribute funds for State run programs, reform minded States were in a bind.

It was necessary to spend money on new and potentially duplicative programs in order to be more creative than the Federal requirements. In Colorado, we finally joined some nursing home resident plaintiffs in suing the Federal Government to reform the survey and certification program.

Mr. WAXMAN. Dr. Robbins, the rest of that statement will be included the record.

Mr. ROBBINS. Would you like me to mention the few conclusions I drew at the end of the statement?

Mr. WAXMAN. If you can do it very briefly.

Mr. ROBBINS. Obviously, I wanted to commend you on the legislation, for finally stating the quality of life issue. Let me deal very briefly with the resident assessment issue.

Resident assessments are required periodically in this legislation, at every change in resident status. This will make the staff observe the residents carefully and provide a basis for audit. It's important to understand that this assessment required in the bill is not a diagnosis because "diagnosis" means a disease process, nor a "prognosis," which means predicting the course of a disease, rather it is a simple description independent of guesses about diagnosis and prognosis, of what the resident can do.

Well conducted resident assessments will prevent residents' problems from being unattended. This is the central piece from the Institute of Medicine's report and in your legislation.

Thank you.

[The prepared statement of Mr. Robbins follows:]

### STATEMENT OF ANTHONY ROBBINS

I am Anthony Robbins. I teach public health at Boston University. I have worked on the problem of protecting nursing home residents during four periods in my career: while a fellow at the Harvard Center for Community Health and Medical Care, I trained with Paul Densen and Ellen Jones who helped develop the system of resident assessment; when I was the State Health Commissioner in Vermont I tried to develop alternatives to nursing home care; when I directed the Colorado Department of Health, the State joined resident advocates in suing for reform of the Federal enforcement system; and until last year, on the staff of this committee, I worked to organize the national review of nursing home enforcement by the Institute of Medicine.

The history of the nursing home industry and its regulation is a relatively brief one in the United States. Only since the passage of the Medicaid and Medicare laws in 1965, have nursing homes flourished in this country. From the beginning, Medicare provided time-limited coverage for care in nursing homes, thus Medicaid rapidly became the dominant payment system for nursing home services. It was the availability of nursing home coverage under Medicaid that lead to the tremendous boom in nursing home resources in the United States. In the late 1960's capital flooded into a bizarre collection of mansions, inns, hotels, rest homes, aged hospitals, and boarding houses to convert them to nursing homes: Skilled Nursing Facilities and Intermediate Care Facilities.

Not surprisingly, the early concerns of the State and Federal officials charged with protecting nursing home residents were for fire safety. Was there any way to make these buildings safe for handicapped and bedridden residents? Thus the earliest inspection and enforcement systems were concerned with the physical structure.

In the first years of Medicaid, the inspection and enforcement system evolved, but the basic concept remained the same. The question was whether the facility had the capacity to care for residents safely. Inspectors looked at the facility for fire safety: door, exists, stairs, alarms, sprinklers, et cetera. Waivers were granted until physical improvements could be made. Inspectors reviewed a growing body of documents: policies, plans, and accounts. And inspectors reviewed the staffing, scrutinizing the number of nurses and their credentials, rather than what the nurses actually did for residents.

Most important, with a system intended to evaluate capabilities, the enforcement system rarely looked at what was happening the residents themselves. I will return to this point, which is the central reform in this legislation! The last 20 years has seen a long line of nursing home scandals. The scandals have always raised the question of whether the States and Federal Government have the proper armamentarium to protect residents of nursing homes from operators who are willing to risk lives in the quest of profit. In the early 1970's, a New York State court made the regulators' dilemma very clear. It held that the State health department was not allowed to remove Medicaid recipients from an unsafe facility without a full administrative process because the facility had a "property" interest in the residents. The court said that the nursing home owned the right to continue to collect from Medicaid.

During the same 20 years, three important developments have changed the situation. 1. Consumer groups have come to the aid of nursing home residents. 2. Some States have been creative and increased their ability to protect residents. 3. The Federal Government, by sponsoring research, has learned how to reform the inspection and enforcement system so that it focuses on the residents.

Consumer activists, including the Gray Panthers, the American Association of Retired Persons, and the National Citizens Coalition for Nursing Home Reform, are responsible for a vast change in public attitudes. Aided by attentive press, these groups have convinced most Americans that there are serious problems in nursing homes. This work is invaluable when seeking to legislate reform.

States have becomes increasingly concerned about nursing homes. For most States the first concern is money. The elderly population is growing rapidly. Nursing home services are the most rapidly growing part of Medicaid. And Medicaid is, in most States, the most rapidly growing part of the State budget. States have restrained the expansion of nursing homes. In most States, the number of nursing home beds per elderly citizen has declined. Thus the residents have become older and sicker on average. This was documented in a GAO report prepared for the committee 3 years ago.

State governments concerned with nursing home enforcement have run head-on into the the Federal enforcement system. Because the Department of Health and Human Services establishes the Medicare rules and requires similar procedures for Medicaid before contributing funds for State run programs, reform minded States were in a bind. It was necessary to spend money on new and potentially duplicative programs in order to be more creative than the Federal requirements. In Colorado, we finally jointed some nursing home resident plaintiffs in suing the Federal Government to reform the survey and certification program. The 1976 case is still tied up in Federal Court, while the Department of Health and Human Services responds to court-ordered changes.

A few States have established new legal remedies to protect nursing homes residents: intermediate remedies or sanctions. (It was difficult to enforce the law against delinquent nursing homes where the only course was to shut them down. The evidence is very clear that moving elderly patients results in a 2- to 3-percent death rate just from the move.) Where adopted, systems of fines and court ordered receivership have made it possible to force compliance without dislodging the residents.

To the credit of the Federal Government, there has been research on nursing home enforcement from the very beginning of Medicare and Medicaid. Drawing on the work of the National Center for Health Services Research, Under Secretary Frank Carlucci, was able to design a national campaign to improve nursing homes in the early 1970's for President Nixon.

The patient classification for long-term care was developed by a consortium of researchers at Harvard and Michigan State. The classification system was a way to describe, reproducibly, the capacity of a patient or resident to perform normal daily activities, such as dressing, eating, walking. By describing a patient in a manner that two observers would make identical descriptions, it was possible to follow patient progress, maintenance of function, or decline. The simple form directed careful attention to the true state of the resident. It made the staff or inspectors into good observers. It could be audited.

Attempts in the Department of Health and Human Services to implement an inspection and enforcement system based on observing that progress of residents or the maintenance of function were not successful. Ironically, the physician-dominated review group within the Health Care Financing Administration blocked implementation because the program would have been based on the idea that nurses can do patient assessments. We discovered this unpublicized doctor-nurse battle while Colorado was preparing to sue the Department.

Interest in true reform seemed to be abandoned altogether in 1981. The Vice President's Task Force on Regulatory Reform made deregulation of the nursing home industry the top priority for HHS. Secretary Schweiker proposed changes in the conditions of participation that would have made it almost impossible to take any enforcement action against a deficient nursing home. This committee and the wholes Congress reacted with proper alarm. A bipartisan burst of outrage resulted in a legislated moratorium on deregulation. There was not enough time to reach a consensus in the Congress on reform, but when the moratorium expired, the committee talked the Department into funding a study by the Institute of Medicine during a self-imposed 2-year moratorium on deregulation.

The Institute of Medicine's report was issued without dissent. Consumers, nursing home operators, and State regulators all endorsed the recommendations. They are incorporated in the bill before you today. This bill corrects all of the major nursing home enforcement problems in the Medical law. Let me comment briefly.

The resident of the nursing home is the central focus of the bill. For the first time, the Congress has recognized that if inspectors look at the residents, nursing home staff and operators will also pay attention to what is happening to the residents.

1. Promoting the maintenance of the quality of life is now an explicit goal.

2. Resident assessments are required periodically and at every change in resident status. This will make the staff observe the residents carefully and provide a basis for audit. It is important to understand that this assessment is not a diagnosis, which means naming a disease process, nor a prognosis, which means predicting a course of the disease. Rather it is a simple description, independent of guesses about diagnosis or prognosis, of what the resident can do. Well conducted resident assessments will prevent resident problems from being unattended to.

3. The bill would require a formal plan of care. The plan of care is where the professional staff of the nursing home, in consultation with the resident and family agree on the resident's needs. These are defined broadly in the bill. They include emotional and psychosocial needs in addition to medical needs. The resident assessment, combined with a diagnosis and prognosis, forms the basis of a plan of care. Needs are a professional judgment of what should be done for the resident; what services should be offered, based on the diagnosis, prognosis, and functional capacity of the resident. The plan of care is not a rigid prescription, as doctors and nurses may differ on how to help a particular resident. However, the written plan of care is set out to be followed by staff until it is changed formally. It is subject to review and revision.

4. The explicit section on resident rights codifies what is common practice in the best facilities today.

5. The responsibilities of the Secretary are spelled out because from Secretary Califano on, until admonished by the U.S. Court of Appeals, all Secretaries argued that they had the authority, but lacked the responsibility to protect nursing home residents.

6. At last, the bill proposes a survey and certification system that includes an efficient strategy to use enforcement resources for compliance. Unless there is going to be a great deal more money available for surveys, it is essential to pick those inspector activities that are most likely to discover problems. Paper reviews should be kept to a minimum. The condition of resident must be the focus, with the intention of seeing enough residents to reliably know whether a facility is doing a good job. The sampling approach, followed by intensive inspections where deficiencies are suspected, is the best way to proceed. Even with more resources, examining each resident on each inspection is not the best way to use the resources, more attention must be directed at problem facilities.

7. The enforcement section is both rapid and moderated. States can act quickly to protect residents in public health emergencies. States must provide the short list of alternative remedies or intermediate sanctions in the bill, but the language is not restrictive and additional creative approaches may be tried and tested by the States.

It will always be up to a State health department to choose when to apply an available remedy. The bill meets the Mikado's test, to let the punishment fit the crime.

8. In conclusion, this is a fine nursing home reform bill. If members of the committee need to understand the logic and strategy incorporated in the complex, sometimes arcane, legislative language, I strongly urge you to peruse the Institute of Medicine's excellent report.

Mr. **Waxman**. Thank you very much.

Mr. Vladeck.

## STATEMENT OF BRUCE C. VLADECK

Mr. **Vladeck**. Mr. Chairman, I appreciate the opportunity to be here today. I commend you and your colleagues on the introduction of this legislation.

I was a Member of the Committee on Nursing Home Regulation of the Institute of Medicine, whose report you referred to in the bill. I can't really claim to speak for the committee since it has been out of business for about 18 months and I'm not sure all of my colleagues would have seen me as their spokesman. I think I can comment on some of what the committee did and its relationship to the proposed legislation.

I think it's important to remember that the study was undertaken by the Institute of Medicine in response to efforts of "deregulation of the nursing home industry" that occurred in 1981 and 1982 and largely as a result of your actions, Mr. Chairman, and those of this committee, those efforts to deregulate nursing homes were put on hold pending the study.

In that regard, I think it is important to point out that the primary findings of the committee were that while quality of care is probably in many ways significantly better in nursing homes on average in the United States in the mid-1980's than it was in the mid-1970's, there continue to be serious problems of inadequate care and more importantly there continues to be a continuing and important need to monitor and enforce standards for quality of care in order to ensure even minimally satisfactory care for particularly vulnerable, particularly dependent people.

We also found and I would emphasize that it is very important that the Federal Government recognize its appropriate role as the supplier of a major source of the revenue, as the provider of guidance for the States, in terms of its responsibility to work cooperatively with the States and administration of what is supposed to be a Federal/State program through Medicaid.

Finally, in terms of findings, particularly in light of some of the comments already today, I think it is important to emphasize that the committee probably spent as much time on the issue of the relationship between quality of care, cost of care and reimbursement systems as on anything else. We came to some conclusions on that I think are important to remind you of, particularly in the current climate.

First we concluded that the available data is kind of limited and it is hard to draw any firm conclusions, but second, to the extent that you can draw conclusions, that the direct causal relationship between quality of care and the cost of service that is often presumed in common discussion, has never been demonstrated by any plausible evidence.

Indeed, you can go to any State in the Nation at any level of cost or reimbursement and find high quality facilities operating under that per diem and low quality facilities with the same average per diem cost and the same average per diem reimbursement.

Therefore, we concluded it should be possible based on what we already know about nursing homes to make significant improvements in the quality of care without substantial additional expenditures on the part of either the Federal or State government. Most of the increase in expenditures we recommended were for survey and enforcement activities rather than in reimbursement.

Having said that, if I can take one more minute to comment on specifics in the proposed legislation, I would particularly applaud you on the merger of SNF and ICF standards on the provision of a statutory basis for residents' rights, on the clarification of relative responsibilities between Federal and State governments in the survey and enforcement process and on the requirements for training of aides and other unlicensed personnel, although I would urge you to be concerned about many people who have worked long and hard in the nursing home industry but perhaps lack the level of literacy, more competency and didactic instruction to meet such requirements and make appropriate provision for them in any legislation.

I am a little concerned about the frequency of resident assessments, about the willingness to permit an executive branch which hasn't been very vigorous about enforcing the rules, to do without the formal Administrative Procedures Act procedures for the issuance of regulations, and I wish you had spelled out a little bit more about what you mean by "quality of life." I think there are some things in the report that could refer to that. There is one last point I want to make concerned with the bill and that has to do with the issue of discrimination against Medicaid recipients. I know it is a very contentious issue and it has been discussed at great length. It has already come up with prior witnesses.

We spent a lot of time on that in the committee as well. We had some rather heated discussions. We came to the following conclusion, which is essentially that there is no Federal legal requirement that any facility enter into a Medicaid provider agreement. If you permit a facility to have a Medicaid provider agreement and at the same time to discriminate against Medicaid recipients, you are putting government agencies in the worse possible kind of situation.

You are telling facility operators, you make the best deal you can at the price you can in the private market and we will guarantee to pay you an amount required by law to be minimally adequate, minimally adequate quality of care, for every bed you can't fill with a better deal, we give you. If at any time the circumstances are more favorable, you no longer have to accept any of our clients.

In that sense, it is a purely one sided kind of relationship. I frankly think the Pentagon would be embarrassed by that sort of purchasing practice. I don't know of any reason why we have to continue to take it. If they don't want to take Medicaid recipients, they shouldn't be able to benefit from the program.

The rest of the statement is in the record, Mr. Chairman. I appreciate the opportunity to be here. I would be happy to take any questions.

[The prepared statement of Mr. Vladeck follows:]

## STATEMENT OF BRUCE C. VLADECK

Mr. Chairman, members of the Committee, my name is Bruce C. Vladeck. I am President of the United Hospital Fund of New York. It is my pleasure and privilege to appear before you today to express my views on the Medicaid Nursing Home Quality Care Amendments of 1987, which you and your colleagues have sponsored.

As you know, Mr. Chairman, I had the privilege of serving on the Committee on Nursing Home Regulation of the Institute of Medicine of the National Academy of Sciences, the report of which, Improving the Quality of Care in Nursing Homes, was issued a little over a year ago. That report, as I understand it, provides much of the basis for this proposed legislation, and I gather I have been asked to appear before you largely as a result. I must add that, while I was pleased to serve on that committee and I am pleased to be here today, I can hardly represent myself as speaking for a committee which disbanded almost a year and a half ago, and which would never have seen me as its official spokesman. The views I present today are wholly my own.

Nonetheless, I thought it might be helpful to provide a little perspective relative to how the Committee on Nursing Home Regulation came into being, what its major findings were, and how the proposed legislation comports, or doesn't comport, with the Committee's findings and recommendations.

As I'm sure you recall, Mr. Chairman, the genesis of the Institute of Medicine's study lay in efforts by the Executive Branch, originated in 1981 and made public in 1982, to substantially "deregulate" the nursing home industry and rely much more heavily on private accreditation processes and the magic of "market forces." The resulting, and I believe quite appropriate, uproar from consumer groups, state licensing agencies, and others, led the Congress, under your leadership, to first postpone for one year the proposed regulatory changes, and then to put them further on hold while requesting a study of the issue by the Institute of Medicine. In response to this Congressional mandate, the Instiute of Medicine appointed a committee of twenty members, including physicians, nurses, nursing home administrators, academic experts, consumer advocates, and others, under the Chairmanship of Dr. Sidney Katz of Brown University. The Committee was appointed in late 1983, and finished its work in late 1985.

After extensive research, investigation, and public hearings, the Committee concluded that quality of care continues to be a problem in the nation's nursing homes. While quality was almost certainly better in the early 1980s than it had been a decade before, too many instances of substandard or minimally-adequate care remain. Perhaps more importantly, the very dynamics of nursing home care, in which the frailest and most vulnerable of our citizens reside for long periods of time in institutions staffed largely by untrained and minimally-paid personnel having limited professional supervision, require constant vigilance towards the quality of care, as unfortunately does the history of too many nursing homes.

In the context in which the Committee's work was begun, its most important finding was thus perhaps that, rather than deregulation, what was needed was a strengthened, expanded, and more vigorous federal role in assuring quality of care. Both the responsibility of the federal government towards its citizens and the mechanics and actual experience of the Medicaid program make a strengthened federal presence essential. Any notion that increased "competition" or strengthened "market forces" can contribute positively to the quality of nursing home care flies in the face both of the logic of the Medicaid program and the experience with nursing homes in this country. Such improvements in quality as have occurred in the last decade or so are largely attributable to strengthened regulatory efforts.

Further, we have learned an awful lot about the elderly and the aging process, geriatric care, the process of quality assurance, and government regulation itself since the last major changes in the federal regulatory role towards nursing homes were implemented in 1974, and it is long past time that some of what we have learned, and much of what we still need to learn, should be incorporated into federal policy.

Finally, the Committee studied at great length the relationship between nursing home quality and quality assurance, nursing home costs, and nursing home reimbursement practices. We concluded, first, that the available data were rather limited, but second, that the direct causal relationship between costs and quality that is often simply presumed is not supported by any available evidence; that there is considerable reason to believe that many steps to enhance quality can be taken without significant cost or reimbursement implications; and that, even in this era of significant budget constraint, there was no reason to delay taking the necessary steps to improve quality for fear of their budgetary implications.

## Strengths of the Proposed Legislation

In addition, of course, the Committee had a long list of specific proposed recommendations, and I would like now to turn to the ways in which the legislation before us responds to them. I would like to begin, Mr. Chairman, by commenting on those parts of the bill that seem to me most consistent with the thrust of the Committee's report.

Beginning at the beginning, I note with some pleasure, Mr. Chairman, that your bill begins with the abolition of the outdated and generally factitious distinction in the Medicaid program between Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs). The importance of a single standard of care for all nursing homes was not only a recommendation of the Committee, but something I have personally advocated for almost a decade. I would make two observations on this issue, however. One, I think it fair to say that the Committee's recommendation for a single level of facility licensure was very much integrally connected to other Committee recommendations for patient-sensitive and case-mix based systems of resident assessment, staffing requirements, and survey protocols. All facilities should be held to the same standards, but expectations about care and services should be tied to the characteristics of patients, not buildings. Second, I think you have found a reasonable preliminary compromise on the issue of nursing staffing standards, pending the development of case-mix based standards, but I hope you would clarify the proposed legislation to make it clear that facilities that are now being held to a higher nursing standard than that contained in the bill should continue to be so, and that new legislation should not serve as an excuse for any weakening of standards that are already stronger.

Second, I congratulate you on providing a strong statutory basis for residents' rights as a fundamental condition of participation in the Medicaid program, and for otherwise rationalizing the conditions of participation along the lines suggested by the IOM Committee. I must confess, however, to considerable puzzlement over the bill's direction that regulatory standards and guidelines such as those necessary to implement these new sections need not be adopted into regulation, but might instead be promulgated informally. I believe all our experience with the enforcement of quality of care standards in nursing homes makes it quite clear that the strongest possible legal basis is necessary for effective administration. If the rationale for the bill's approach is impatience and dissatisfaction with the Health Care Financing Administration's track record in issuing regulations to implement Congressional direction in recent years, I can certainly sympathize, but I hope you can find a better remedy to that problem.

Third, I must applaud, largely without demurrer, the bill's provisions on survey and enforcement, and the relative responsibilities and roles of federal and state governments in thos processes, although again I am concerned with the issue of formal regulations as opposed to administrative guidelines. The bill's provisions follow very closely on the IOM Committee's recommendations. In a number of areas, such as federal survey of state-operated facilities, I believe they even improve on them.

Finally, I am also in considerable agreement with the bill's provisions on training aides and other unlicensed personnel, which represents perhaps the single most important measure contained in the bill towards improving quality of life and quality of care for most nursing home residents. I am concerned, however, with the possible discriminatory effects implementation of such provisions might have on many aides who have worked hard in the nursing home industry for many years, and who give very good care, but who might have considerable difficulty with formal didactic instruction. I would thus urge you to add some provision in the legislation to "grandfather" in aides who have worked continuously, with a good record, in particular facilities for, say, five or more years.

Concerns About the Proposed Legislation

There are, however, three areas in which I am concerned about the bill's provisions. First is the issue of resident assessment. I am pleased to see that the bill would require periodic resident assessment utilizing standard instruments, but I believe the current language is inadequate. Assessment should be required semi-annually, if not quarterly, as well as on admission and at any time there is significant change in patient status. Further, while functional assessment is essential, it is not adequate by itself. The mandated periodic assessment process and forms should include cognitive and psychosocial function, and must be integrated with both medical and nursing assessments and the patient's plan of care.

Second, I am pleased to see the bill incorporate the Committee's concern for quality of life as well as quality of care, but dismayed to see that standards for quality of life are totally absent. In particular, maximization of patient freedom of choice and of taste, along with dignified and respectful treatment, need not, perhaps, be spelled out in detail in statute, but more specific and directive expressions of legislative intent would be highly desirable.

Finally, I come to what I know is the highly contentious issue of discrimination against Medicaid recipients. I know that issue has caused considerable controversy among the interest groups with which you have discussed this proposed legislation, and it was the subject of extensive discussion, some of it rather heated, among the members of the IOM Committee as well. I would add, if you couldn't otherwise guess, that I have strong personal feelings on the subject myself.

The IOM Committee finally agreed that, since there is no federal legal requirement for any health care facility to enter into a Medicaid provider agreement, facilities with provider agreements should be forbidden from discrimination. The contractual benefits are obtained by the provider, while the provider's obligation to serve government beneficiaries remains entirely up to the provider's discretion, on a case-by-case as well as overall basis. The Committee thus felt that, should a provider enter into a provider agreement, part of that agreement should be a willingness not to discriminate among potential admissions, or among residents, on the basis of payment source.

If providers don't want to take Medicaid patients, they shouldn't take any. Otherwise, the government finds itself in the position, vis-a-vis providers, of saying that you should strike the best deal you can get in the private market, and then, to the extent you can't fill all your beds in that market, we will in essence guarantee to fill the rest of your beds, at a rate required by law to be at least minimally adequate to cover your average costs. Even the Pentagon would be embarrassed by that kind of purchasing policy. Still worse, the government not only says that it will pay for whatever beds you care to give us after you have tried to fill them with private-pay patients, but also says, through the Medicaid spend-down, that providers should attract as many private patients as they can and charge them as much as possible in order to obligate the government to pay for their care. That's downright obtuse.

State and federal governments are being treated like suckers by nursing home operators who discriminate against state and federal beneficiaties, and there is no compelling reason to permit that to continue. If facilities don't care to live under Medicaid cost constraints, they should drop out of the program. I would emphasize again that existing law requires Medicaid to pay nursing homes and other providers rates at least minimally adequate for services of adequate quality when rendered efficiently. I recognize that many states attempt to observe that requirement largely in the breach, and that federal oversight of that responsibility has been minimal at best. But that's no justification for continued discrimination against Medicaid recipients. Existing law pertaining to reimbursement practices should be enforced, but the disgrace of discrimination against Medicaid recipients should be outlawed immediately.

## Conclusions

As is only to be expected from such a committee, the IOM's Committee on Nursing Home Regulation also recommended a number of steps to be taken in research, development, and experimentation around issues of data systems, case-mix measurement, standards development, and reimbursement systems. I would urge you, however, not to ignore such recommendations, however expectable or pro forma they might appear to be. As I'm sure you would agree, the Medicaid Nursing Home Quality of Care Amendments of 1987, while they represent an enormously positive step, are only a first step in what will need to be a long and complex process through which we seek to assure the best attainable care for all nursing home residents. I very much hope the bill is enacted in something very close to its present form, but I'm sure you would agree with me that if it is, we will still have considerable work to do. I share your apparent sense that legislation is indeed the art of the possible, and that incremental steps are infinitely better than none at all, and I am sensitive as well as to the constraints of legislative jurisdiction and sensible draftsmanship. But if we are going to do still better, we are going to have to learn quite a bit more about how to do so.

As you know, Mr. Chairman, I last had the privilege of appearing before you on the subject of reauthorization of the National Centers for Health Services Research and the National Center for Health Statistics. In normal times, it should not be necessary for the Congress to have to exercise such diligent oversight, or enact such detailed and specific authorizations and appropriations, relative to the research and development functions of executive branch agencies responsible for the administration of programs which consume annually billions of federal dollars, and affect in the most intimate possible way the lives of millions of our citizens. But these have not been perfectly normal times, at least in that regard, and I would thus call on you to consider adding to your bill, or at least the accompanying Committee report, specific direction to the appropriate administrative agencies to undertake the necessary research and development efforts.

In sum, Mr. Chairman, I am pleased today not only to comment on the Medicaid Nursing Home Quality of Care Amendments of 1987, but to offer my admiration and support for the thrust of the legislation, and my few specific observations as to how an extremely valuable piece of legislation might be further improved. I think enactment of this bill would constitute a vitally important step forward, which would contribute significantly to improving the lives of more than a million of our most vulnerable Americans, and the millions more that will come after them.

I would be glad to respond to any questions you might have.

Thank you very much.

Mr. **Waxman**. Thank you very much.

Just something on that last point. How do you deal with the claim by nursing homes that if there is a provision that prevents them from discriminating against a Medicaid nursing home patient, they will end up with all of their patients on Medicaid, and because of lower reimbursement, they won't be able to stay in business?

Mr. **Vladeck**. Again, there is existing Federal statutory law having to do with the requirements for State plans relative to nursing home reimbursement under Medicaid. I acknowledge that many States have attempted to honor that law in the breach, and it is clear that for at least the last 7 or 8 years, HCFA has had absolutely no interest in enforcing it.

Nonetheless, it seems to me that it is a more appropriate step to say if you are going to pay for Medicaid patients, you should pay a minimally adequate level, and once you have assured the minimally active level for Medicaid patients, you should pay a minimally adequate level, and once you have assured the minimally active level for Medicaid patients, then I don't believe that operators of facilities can plausibly argue that taking only Medicaid patients will be economically feasible.

Mr. **Waxman**. We are living at a time when governments are trying to avoid paying the minimum level that is acceptable, and the States are coming in with lower reimbursement rates and some of the institutions feel they can't handle their responsibilities at those rates.

Mr. **Vladeck**. I think if you look in the aggregate, Mr. Chairman, you will find that the willingness to accept Medicaid recipients by facilities varies very considerably across States with very different levels of reimbursement, and levels of reimbursement have a lot more to do with local politics and local labor contracts than they do with the requirements for providing high quality services.

Where I live, we average, New York City Medicaid probably averages in excess of $100 a day in per diem rates to nursing homes. In Westchester or Rockland Counties, for example, right across the river in New Jersey, they probably average $45 a day drawing on much the same labor market. Having worked in the New Jersey Department of Health, I think they have better nursing homes in New Jersey and they are paying half as much.

Mr. **Waxman**. Dr. Robbins, it is clear from the previous panel that if you are a Medicaid patient, you don't have many options if you are in a poor quality nursing home. It is very difficult to find alternative placement. Unless you have a very active family council, the quality of care depends almost entirely on State monitoring and enforcement.

You have dealt with the nursing home quality problems as a top State health official in Colorado, where you distinguished yourself by pursuing an active quality improvement policy. Why is it that many States do not have more active monitoring and enforcement efforts, and what more could we do in this bill to encourage vigorous State monitoring and enforcement?

Mr. **Robbins**. At the present time, all of the States are playing by the Federal rules. Bruce has just alluded to the fact that HCFA is not pushing the States to actually carry out those rules, but the rules are flawed, and at the present time the survey certification system is still focused on the capability of the nursing homes to deliver services. They tend to be paper reviews, structural reviews, and rarely do the actual residents and their problems get looked at.

The thing that has been proposed in this legislation is to refocus the whole inspection system on the residents, have the inspectors look at the residents, have the facilities keep records on the residents which suggest that they have actually looked at the condition of the residents, the residents' ability to function. By doing that, you can take the same kind of resources that are now available to the States and paid for largely by the Federal Government and focus on the residents themselves.

It even lets you take a look at a nursing home in a rather more cursory way by looking carefully at a few residents selected at random and deciding whether you have got problems there, and then focusing your real efforts and your real resources on the facilities that have problems.

If there were more resources, then every patient or every resident should be looked at very often by the State, but if we are not going to have new resources, we need to figure out a way to focus first on the residents and then particularly on the homes where the residents are not doing well.

Mr. **Waxman**. Mr. Vladeck, over the next 3 years the bill would follow the IOM recommendation and eliminate the distinction between intermediate care facilities and skilled nursing home facilities. Did you know there is a considerable opposition to this concept primarily because of the added costs that would result to the Federal and State governments? Some argue that eliminating the distinction might create access problems for individuals with high care needs. Do you believe there is any merit to these arguments?

Mr. **Vladeck**. Let me say two things, if I may, about that, Mr. Chairman. First, the committee looked at this issue of the cost implications of the single standard very extensively and became quite convinced at the time, a little more than 1 year ago, that nobody really knew what the actual cost implications would be because HCFA hasn't bothered to collect the minimally necessary monitoring data to know what nursing staffing levels are in facilities around the country. That is the major theoretical cost implication of requiring intermediate care facilities to upgrade nursing coverage.

But even if you speculate as to what the most extreme case would be, it would be only a tiny fraction increment relative to what States are now paying to nursing homes under Medicaid.

On the issue of access to care, I think, in fact, that having a single level licensure tied eventually to patient-specific assessment and to reimbursement that is sensitive to case mix ought to improve access, and the experience in States that have tried to move in that direction would confirm that. Basically, you are having everyone in one queue as opposed to two queues. Theoretically, you ought to have better access.

Perhaps more importantly, nothing, I think, in this whole situation is more tragic than to have a long-term nursing home resident who has been in a facility for a period of time and has gotten used to it and has made that their home arbitrarily moved to some other facility because of some bureaucratic categorization for which there is no scientific rationale, for which there was never even a very good public policy rationale. It doesn't get us anywhere to maintain the two levels of care.

Mr. **Waxman**. Mr. Wyden.

Mr. **Wyden**. Thank you, Mr. Chairman.

Dr. Robbins, the bill as it is written now replaces the current survey and certification process under which the facilities are reviewed for compliance with the requirements with the new concept. The two-step process under which those facilities that do poorly on a short, standard survey would have to undergo a comprehensive extended survey. Now, there has been a fair amount of debate about this, and there are some that contend the current arrangements are better because they would require each resident to be seen by a surveyor at least once a year.

A question to you, Dr. Robbins, would be: What do you think the effect would be on the quality of care with this new two-step process given the fact that there seems to be some debate on it?

Mr. **Robbins**. With the old system, the current system, the focus, as I said, was on the capability of a home to deliver services. Now, there are some minimum requirements that would have to continue to be looked at. The fire safety issues. Those are not to be done away with. But by refocusing the inspectors to look directly at the residents and to assess a group of residents very carefully in a way that was never done in the past and do it in a way that doesn't confuse the questions of diagnosis and prognosis but looks at that resident and what he or she can do at a particular point in time, that then requires that the facility keep comparable information about each resident, that that information must be updated every time there is an observed change in the functioning capacity of that resident.

The choice of which residents to audit when you inspect would obviously be made by choosing to audit one who have been reviewed recently within the home so you are comparing their observations with the inspector's observations, and in this way you have refocused the whole system on what is happening to the residents.

Now, if you do that, you are then in a position, by looking at a sample of residents—obviously, it would be nice to look at all the residents each time you are inspecting a facility, but resources don't seem to be increasing rapidly. You look at a sample, decide whether this in general is a facility that is doing well by its residents, and if it is, you concentrate your resources on the facilities that aren't doing well.

It is essentially an efficiency matter, and it focuses on the residents themselves. That should be in advance given a fixed level of resources.

Mr. **Wyden**. One other question, if I might. I think you all have heard that I am working on legislation to increase the personal needs allowance $10 a month. There is money provided for in the budget, so it is really a question of the mechanics of how we work on this bill.

What I would be interested in hearing is how we help the States define the Medicaid benefit so you don't have a situation where the

Congress increases the personal needs allowance. And then isn't used at the State level for those personal needs but is used for medical costs and it doesn't go for what it is intended.

Mr. Vladeck.

Mr. **Vladeck**. I think the timing may not be optimal, but the way to do that is to write your standards for nursing homes under Medicaid to include in the provision of services things that you think ought to be provided by the facility rather than paid for out-of-pocket by residents.

If I could just say one thing, one of the tricks that the States have undertaken over many years is to unbundle what goes in a nursing home payment, including now most physician services and, in many States, most drug service, most drugs, as well as therapists and so forth. That has two implications, it seems to me. One is that the per diems look a lot lower than they really are if you figure what Medicaid is paying for all the services the resident is receiving. A second is that the State, under an illusion of saving itself money for purposes of political appearance may not be saving itself money but is creating disincentives to optimal care of residents.

Mr. **Wyden**. One last question. Do all of you think there is a significant illiteracy problem in nursing homes today among the employees? If so, how does that manifest itself in patient care and what can we do about it?

Mr. **Vladeck**. I don't have any systematic effort, but if you look at the data on literacy and then you look at who is hired to work as aides and orderlies in nursing homes, it would be astonishing if there were not.

Mr. **Robbins**. I have nothing further to add.

Mr. **Wyden**. Thank you, Mr. Chairman.

Mr. **Waxman**. Thank you, Mr. Wyden.

Mr. Sikorski.

Mr. **Sikorski**. Thank you, Mr. Chairman.

Thank you both for your thoughtful analysis. Am I accurate to focus on how much money we put in the system? You have to have a physical plant that meets basic fire and safety and other sanitary and convenience and comfort standards. You have to have professionals paid at least an amount attractive enough to get them off of the cash register at the local supermarket and into a program where you are touching people and not cash registers, and you have to provide social and recreational and occupational and physical therapy kinds of services, and then you have to provide something that attracts people to put their capital investment into it.

I look at per diem rates in various States and I can't believe that you are going to have quality of care in States that have half the per diem rates that Minnesota does without scandals, without terrible circumstances. Deep Throat said follow the money. Is my focus on the money misguided?

Mr. **Vladeck**. Let me say a couple of things if I might. First, it is critical to distinguish between the amount of money that is paid to a facility and the amount of money that is spent on patient care. We have never developed an appropriate mechanism, and now we don't believe it is ideologically acceptable to have a mechanism that traces that money back to actual patient care expenditure.

In fact, there was some unhappy experience in California within the last several years in which the legislature sought to raise wages to the lowest rung of nursing home employees by making an additional Medicaid payment earmarked specifically for salary increases, and there was no way ever to track that money. Now, of course, our belief in Washington and elsewhere is you shouldn't have cost-based reimbursement, you should provide people incentives.

Our experience in the nursing home industry with paying dollars out in the hopes that it would improve quality of care and then watching where it flows has not been an entirely happy one and we are probably less capable of enforcing that connection now than we were in the past.

Second, if you look at the real contributors to a high quality nursing home as opposed to a poor nursing home, much of it has to do with continuity of ownership and management, for which excessive financial incentives are probably a deterrence. You don't want people to treat it as an attractive real estate investment or to turn it over whenever depreciation starts to fall below amortization costs.

With the quality of nursing management, and third with the motivation and leadership of staff, which in most communities is not tied in any systematic way to how much you are paying that staff. So I think clearly there is a minimal level of adequacy below which even the best-managed, most efficient home can't provide decent care, and I suspect in some States we are very close to that or below that in the Medicaid program.

But I can tell you we have looked at this issue in New York for a long time. We pay a fortune in New York for nursing home care. We have the most glorious scandals of anyone, as well as the most extensive surveillance efforts, and the best we have been able to figure out over all this time is following the reimbursement dollar down to improved patient care is almost impossible for a State-administered program.

Mr. **Robbins**. I think that is a brilliant answer and I would only call your attention to the fact that you do pretty well in the State of Minnesota, from reports that I get, in terms of patient care. I don't think it is due primarily to the fact that the reimbursement is generous. I think that the people of the State, the consumer groups and State government have really been attentive to nursing homes, and it makes a difference.

So it is possible to improve quality by focusing on the quality and not only on the money.

Mr. **Sikorski**. Thank you.

Thank you, Mr. Chairman.

Mr. **Waxman**. Mr. Walgren.

Mr. **Walgren**. Thank you, Mr. Chairman.

To try and follow up, you are stating the conclusion that you cannot trace the reimbursement dollar down to quality of resident care and that it hasn't been able to be done, but I guess I don't get a sense for what intervened, for why it can't be done.

Mr. **Vladeck**. Dollars are fungible, Mr. Congressman. That is the most important part. You can go through the most elaborate rate-setting exercise in the world, and I have been part of them, in which you say, well, the median raw food cost in New Jersey nursing homes is $2.73 a day, and we want our residents to eat well so we are going to put $3.04 a day in raw food costs into the rate, and we think the nursing standards at this level of skilled intermediate mix requires so many aides and so many RN's and so many LPN's, and we can calculate out what that costs and we know what the wage levels are and the fringes are.

You add it all up and you moosh it around, and it is $47 a day, and there is nothing in the world to prevent the operator from taking that check and buying a Cadillac with it.

Mr. **Walgren**. But can't you see that happening? Can't you go in and see that instead of a certain mix of staff skill, the money was used to increase the rate of return or to do something else?

Mr. **Vladeck**. I have never seen a State government which was prepared to make the investment in auditors and accountants sufficient to outdo the auditors and accountants of providers of service. I think there is another important issue, too. If you do, as in New York, attach this very extensive regulatory apparatus—and try, when we had 80 people in the special prosecutor's office all auditing nursing home cost reports—you continue to find that even in certifiable acceptable situations in which the money was being spent for what it was supposed to be spent, you had enormous variations in quality of care.

Mr. **Walgren**. But would that be, I gather, because what leads to quality of care has a very high mix of noncost factors?

Mr. **Vladeck**. That is right.

Mr. **Walgren**. You identified the continuity of the ownership. I gather that means the identification of the management with the community and the care and the families. You identified the motivation of the staff. I gather that has much more to do with a sense of community than it might with—well, I don't know. I suppose that is what motivates staff to care. Who is a caring staff? Does that mean nuns do this better than those hired under the local public works program?

Mr. **Vladeck**. At the risk of sounding like a cliche, I think it is true that a lot of it has to do with the caliber of management. I think well motivated employees tend to be those who work in well managed facilities where the people who supervise them are good supervisors, and the people who supervise the supervisors are good supervisors. That is regardless of wage rate.

Mr. **Walgren**. So there is no substitute to the morale that comes from good management.

Mr. **Vladeck**. I don't believe so, not in facilities where people live all the time and where they receive very intimate kinds of services.

Mr. **Walgren**. But can you separate out from that the third quality which you mentioned, which is the degree of training of the nursing component? That has to be something that is very cost-based, I would gather. In your looking at this area, do you see an improvement in the quality of the care as the nursing professionalism is increased?

Mr. **Vladeck**. Some of my colleagues in the nursing profession argue that you do. Folks at the University of Pennsylvania who have been running the teaching nursing home program have collected a lot of data and are now trying to demonstrate that if you add more RN services to a nursing home, you both improve the quality of care and reduce total costs because your patients are hospitalized less often, are sent to emergency rooms less often and so forth.

We don't have a whole lot of data on that issue. I would say one thing, however. Again on the issue of training of aides, for example, the last data we have, which is very old, from the Bureau of Labor Statistics show turnover rates among aides at 70 to 100 percent a year. If at the same time you spend x dollars on training, you reduce that turnover rate to 40 percent, and if you make the heroic assumption that facilities always meet minimal staffing requirements—in fact, with high levels of turnover, they are often below minimum—but if they are to meet minimum, then, in fact, if you can use training to reduce turnover rate, you probably come out ahead in total expenditures.

Mr. Walgren. But just the observation, Mr. Chairman, that turnover would, I think, be most addressed by dollars than almost anything else, would it not?

Mr. Vladeck. Again, it has been argued and the folks in Kansas who were early into nurse training have suggested, but the data is still not very strong, that if you train people for what they are going to do, you reduce a lot of the turnover at the front end that people who come in for 3 weeks are totally horrified and totally lost and leave very quickly. If you have preemployment training, you can cut into that very substantially.

Mr. Walgren. Thank you, Mr. Chairman.

Mr. Waxman. Thank you, Mr. Walgren.

Mr. Whittaker.

Mr. Whittaker. Thank you, Mr. Chairman.

I have some questions for either one of you gentlemen, and I had to leave the hearing for a couple of appointments out in the hall, so forgive me if these are duplicative. In fact, if they are, please tell me because I will look at the record then.

I understand that in the coming panels we are going to have some administration witnesses who are going to testify that H.R. 2270 could be implemented through regulation. Do you think HCFA should be allowed to publish the proposed regulations that address nursing home regulations before the committee would mark up the bill that we are considering today?

Mr. Robbins. Mr. Whittaker, I am no longer a party to the lawsuit that the State of Colorado brought against the Department, I guess starting around 1977 when we joined the plaintiffs. The fact is that we argued that the Department could do all these things, could make the necessary reforms, that they ought to do it, and if they are not doing it, they ought to be ordered to do it because their responsibility was to protect the residents of nursing homes.

They came back into court and argued that, yes, they probably had the authority but not the duty to do that, so we find ourselves—you find yourself in a legislative bind, which is that they may be right that they could do a lot of this under the current law, maybe not all of it, but they clearly haven't, have chosen not to, and maybe the most distressing thing that we discovered in the process of suing the Federal Government was that it was the physicians within HCFA who got upset about any kind of a scheme that indicated that nurses could actually make decisions about patient care and what ought to be done for nursing home residents.

So that all of a sudden the reform, which was an effort to focus on what is happening to the residents and make sure that everyone from the nurse's aide up to the chief nurse in a facility really knew what was happening to the residents, that was rejected as an impossible concept by the physician groups within HCFA by, I think it was, the Health Services Quality at the time. I don't know what that unit is called today.

So this legislation needs to go forward because the administration has not carried out this reform. And it is not just this administration.

Mr. **Whittaker**. Yes, I am aware.

Do you believe that the passage of this legislation would affect the States' decision to place a moratoria on nursing home construction?

Mr. **Vladeck**. I think the States have all the incentive they need right now to put moratoria on nursing home construction. In the absence of these regulations, they have been doing it on and off continuously over the last decade. I think the question of nursing home supply is very complicated and the States have some very tough decisions whether or not this legislation is enacted.

Mr. **Whittaker**. Would you give me a brief thumbnail synopsis of why the States are considering the pros and cons on nursing home moratoria construction?

Mr. **Vladeck**. Let me, if I may, speak to that a little bit because of some research in which we have just been involved in at our organization. In New York, which, of course, is the extreme case of a State with a regulatory posture toward its health care industry, we made a very conscious decision about 10 years ago that our system of long-term care for the elderly over-emphasized institutional services, that we were putting all our dollars into institutions and not adequately providing community-based care for those among the frail elderly who would prefer it and might benefit from it.

In order to implement a strategy to move people—not people who are now in nursing homes, but to move the system of provision of care for the elderly from an institutionally-based system to a community-based system, you have to do two things. One is you have to put the money and the resources and the people into developing community-based care, but in order to have the money, the way the Medicaid program works, you have to stop increasing at 15, 20, 25 percent per year what you are spending on nursing homes.

As long as you are adding new beds to the system all the time, if you are keeping rates anywhere close to inflation you are going to be spending every conceivable new dollar not only in the Medicaid program but in the whole State budget playing catchup with new nursing home capacity. The only way to generate any funds with which to pay for other services under the Medicaid program has been to say we are paying for x amount of nursing home care, next year, 3 years from now, we want to pay in addition for y amount of home care or y amount of pediatric services or whatever.

In a number of States, we now have about 50 percent more people in the City of New York in the Medicaid program receiving community-based home care services than we have in nursing homes. That was done on purpose and is something I think we are proud of, but we could not have done it if we had permitted continued construction of new nursing homes.

Mr. **WHITTAKER**. That probably could very easily fall under the definition of social engineering.

Mr. **VLADECK**. Well, we call it health planning.

Mr. **WHITTAKER**. It is a fascinating concept.

Thank you, Mr. Chairman.

Mr. **WAXMAN**. Thank you, Mr. Whittaker.

Mr. Vladeck, Dr. Robbins, thank you very much for your testimony.

Our next panel of witnesses represent nursing home owners, operators and physicians. Dr. Paul Willging is Executive Vice President for the American Health Care Association. Mr. Michael F. Rodgers is Deputy Executive Vice President for Policy and Program Implementation with the American Association of Homes for the Aging. Dr. Raymond J. Baxter is Vice President for Corporate Planning with New York City's Health and Hospital Corporation. Finally, Mr. Paul Kerschner is Executive Director of the American Medical Directors Association, a group that represents physicians working in long-term care facilities.

We thank each of you for coming here this morning to testify before us. Again, we will have your prepared statements as part of the record. We are going to have to be very strict about the 5-minute oral presentation.

Mr. Willging, why don't we start with you.

## STATEMENTS OF PAUL R. WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION; MICHAEL F. RODGERS, DEPUTY EXECUTIVE VICE PRESIDENT, POLICY AND PROGRAM IMPLEMENTATION, AMERICAN ASSOCIATION OF HOMES FOR THE AGING; RAYMOND J. BAXTER, VICE PRESIDENT FOR CORPORATE PLANNING, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION; AND PAUL A. KERSCHNER, EXECUTIVE DIRECTOR, AMERICAN MEDICAL DIRECTORS ASSOCIATION

Mr. **WILLGING**. Thank you, Mr. Chairman.

It is a privilege to testify before this subcommittee today on a most critical issue. I am the executive director of the American Health Care Association, which is the Nation's largest trade association representing facility based long-term care services. I represent, through 9,000 facilities across the country, some 900,000 patients and residents within those facilities.

It appears that the Institute of Medicine study is coming to a long-awaited conclusion and one that has not only been long awaited but, I think, in terms of those who have dealt with its recommendations, long desired. I think it important to recognize within the Institute of Medicine study the recognition within the study that the nursing home industry has made great strides in improving the quality of care over the last 15 to 20 years while at the same time recognizing that much yet needs to be done.

I think it important to note, however, that many of the concerns raised in terms of the unfinished agenda were no longer related to the problems we had in the early and midseventies in terms of life, safety and basic quality of care issues, but more we have moved to a new plateau, referring now to quality of life and some of the elemental safeguards in terms of dignity and the type of care provided within a home setting.

I think it important also to recognize, Mr. Chairman, what has been accomplished since the Institute of Medicine was published, particularly with respect to enforcement and some of the new activities undertaken by the Health Care Financing Administration is the enforcement arena. Some tough new programs have been put on the books and are being implemented, ranging from intermediate sanctions, regulations, new fast track termination procedures, and new and strengthened look behind authorities for the Federal Government.

In 1986, 71 nursing homes were involuntarily terminated from the Medicare/Medicaid programs. Since July of 1986, 374 such terminations have been initiated, 37 of them on the fast track approach. So while much has been done in the enforcement arena, I think there is still a considerable unmet agenda yet to be dealt with, and indeed, the Institute of Medicine study itself did not focus as its primary concern with enforcement mechanisms but rather the type of care and review of care provided within America's nursing homes. It focused on things such as resident assessments, on plans of care, on changing the survey and certification process from one oriented toward process and input for the care actually provided patients.

It was with this in mind that a group of over 20 concerned organizations have been meeting over the past 6 to 9 months, organizations representing consumers, providers and professionals dealing with the more essential aspects of the Institute of Medicine study. It was this group which on April 24 of this year published 12 consensus documents, consensus documents since adhered to by 51 groups across Washington and the country with interest in this regard.

This consensus activity focused on two questions: What of the Institute of Medicine recommendations is not yet accomplished; and what of those as yet unfinished items on the agenda are doable today?

I have some concern, Mr. Chairman, that House Rule 2270 introduced by you and Congressman Dingell is not yet moving toward that new view of the future of what is yet to be done in terms of the Institute of Medicine study but to some extent is still preoccupied with some of the concerns of the past, largely with respect to enforcement, and beyond enforcement, with the presumption of guilt as far as nursing homes are concerned, guilt until proven innocent.

I know that is a strong statement, but I am worried about such provisions in your legislation, Mr. Chairman, which suggest that if a State review of a nursing home finds difficulties, yet if a Federal look behind looking at that same nursing home finds no difficulties, the facility is still guilty, but the State's reviews pertain and prevail in that regard. I am concerned about the attitude that such a provision reflects.

I am also concerned, Mr. Chairman, about the degree to which H.R. 2270 doesn't fully recognize some of the implications of dealing with what is the unfinished agenda, moving to different types of standards as we review nursing homes. Let me start with enforcement.

Your legislation applies eight new types of sanction, four at the Federal and four at the State level. I have mentioned already the implication of guilt until innocence is proven. It indeed extends these sanctions down into the institution at levels never before contemplated as far as enforcement actions are concerned, such as a fine for anyone who wrongfully fills out a resident assessment.

I think enforcement is important, Mr. Chairman. I think improvements made in the industry, quite frankly, are to some extent a result of the enforcement that has taken place over the last 15 to 20 years, but I would suggest we are already seeing progress in that regard and that the Federal role would be to continue to police and to police with greater strength what it is the States are doing, not to tell the States how best to do it.

With respect to standards, I am concerned, again, about the failure of H.R. 2270 to recognize the practical fiscal implications of simply moving ICF's up to SNF standards, and indeed, I would refer back to the consensus documents, which recognize that just as there is no such thing as a generic nursing home patient, there is no such thing as a generic nursing home; that one should start with a review of the needs of the patient and then move to acuity based reimbursement systems which both recognize and cover those needs.

I think H.R. 2270 lacks that recognition. There is indeed in the legislation proposed much more attention devoted to mechanisms to assure that the survey process is funded than to assure that the new standards are funded. In summary, I would say let us recognize that there is, as yet, an unmet agenda. Let's be practical, however, in our response to that agenda and let us not hold out false promises to the American people that it is providing new standards without the resources to pay for them.

Thank you.

[The prepared statement of Mr. Willging follows:]

## STATEMENT OF PAUL R. WILLGING

Mr. Chairman and Subcommittee Members:

I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), the largest organization of America's long term care providers. AHCA's membership exceeds 9,000 long term care facilities which care for about 900,000 residents each day. And importantly for this hearing, AHCA is partner with over 50 national consumer, professional, and provider organizations in recommending a comprehensive package of nursing home regulatory improvements.

Last year the Institute of Medicine (IOM) of the National Academy of Sciences issued an important report, Improving the Quality of Care in Nursing Homes, which reflected two years of study by experts in long term care. The study, which this Subcommittee was instrumental in generating, revealed that while nursing home providers have made great strides in delivering quality care, room for improvement still remains. The study also concluded that nursing home standards should be rewritten, that the federal and state inspection process should be overhauled, and that nursing home standards should be strengthened. With recommendations that have been found to be realistic and responsible, the IOM report has become a framework for regulatory and legislative reform.

It is important for the Subcommittee to understand that the long term care inspection and enforcement system has changed dramatically since the IOM completed its study. In fact, most of these changes have occurred because of the IOM study. I would like to highlight the four most potent regulatory changes.

First, inspection of nursing homes is undergoing major upgrading. A new federal long term care survey program, know as PaCS (for Patient Care and Services survey), has minimized the review of nursing home paperwork and instead is forcing inspectors to pay attention to actual patient care and patient satisfaction. Subjects previously buried within the old survey process are being given great importance, such as whether patient privacy is adequately protected and whether the patient gets the right medications at the right time. The new survey is more intense, more detailed and more patient-oriented than the former system. More deficiencies are being identified, not because care is declining, but because inspectors have changed their focus -- and rightly so.

Second, stronger, faster procedures have been put in force by the Health Care Financing Administration (HCFA) to terminate Medicare or Medicaid participation for a nursing home which does not meet requirements of the programs. Any due process rights take a back seat to swift, deliberate action by the HCFA regional office and state survey agency. No longer can a chronically substandard facility continue to participate due to sluggishness of the survey agency or protracted efforts to correct deficiencies. Either the facility "shapes up," or is out.

"Fast track" termination must take place within 5 to 23 days if patient health or safety is in "immediate and serious jeopardy." If deficiencies do not pose such a serious threat, termination occurs within 90 days. As you can imagine, even the notice that termination procedures have begun provides a powerful weapon to bring about quick correction of any deficiency and to maintain program participation. Yet, the first year these tougher procedures were used, at least 58 facilities were terminated from the Medicare or Medicaid programs.

The third change occurred last August when HCFA implemented its authority to ban new patients. Under this new intermediate sanction, a facility may be prohibited from admitting new Medicare or Medicaid patients if it is out of compliance with regulations which do not threaten patient health and safety. We expect this penalty to be used as aggressively as the new termination procedures have been used.

The fourth change has been a more aggressive use by HCFA of its authority to "look behind", or check up on, state surveys.

Possibly the most significant change brought about by the IOM study has been a cooperative effort by consumer, professional and provider groups to reach consensus on comprehensive legislation needed to move forward the reforms recommended by IOM.

This effort sought to change the historical nature of discussions of nursing home legislative and regulatory reforms which had been characterized by confrontational postures and unproductive stalemates. There was a conviction among the participants that the points of agreement were vastly more numerous than the points of disagreement and that the disagreements should not stand in the way of needed change.

Out of intensive and extensive discussions an unprecedented consensus was forged on what constitutes the most constructive and realistic improvements in nursing home regulation, at this time. The results of that year-long effort were released on April 24 in what we believe will be looked upon as a major turning point in national long term care policy. AHCA is proud to have been a part of that ambitious undertaking. This landmark package has the additional support of such groups as the National Citizens' Coalition for Nursing Home Reform, the American Association of Retired Persons, American Nurses Association, and the National Council on the Aging.

Clearly, the 15 months since the IOM report was released have been a watershed for nursing home quality and enforcement of federal and state regulations.

If the litmus test of a "consensus" is reflected in concerns by some for "going too far, too fast" and by others for "not going far enough now," this package surely passes the test. But what the package does answer are two paramount questions, "What are the most critical and as yet unmet needs?" and "What is doable now?" We believe the changes are not only doable now, but would constitute the most significant nursing home legislation in 20 years -- or the tenure of each member of this Subcommittee.

Since the release of the IOM report, there have been a number of legislative proposals which have sought to implement its recommendations. The most recent of the bills has been introduced by you, Mr. Chairman, along with Chairman Dingell, as H.R. 2270, the Medicaid Nursing Home Quality Care Amendments.

At this time I will neither belabor the problems with the present system of nursing home regulation and enforcement nor detail their legislative remedy. Many of the provisions included the Dingell-Waxman bill are, I think, consistent with the consensus of the national aging and health organizations. For those, I applaud your leadership and encourage your action. At this hearing, however, I would like to highlight two significant differences.

Just as consensus building has been occurring among national organizations, the series of major Congressional proposals could have been be viewed, over time, as focusing more on what is as yet undone but doable. Unfortunately, I find the

Dingell-Waxman bill has generally not had similar refinement, with most of the contentious provisions in last year's version repeated and several new ones added. In contrast to the consensus package, there are no instances in which Dingell-Waxman is more constructive. Rather it seems to be pre-occupied with yesterday's agenda.

AHCA has already submitted information to the Subcommittee detailing the consensus provisions as well as specific comments on the provisions of the Dingell-Waxman proposal. There are two issues which pose the clearest and most significant difference between H.R. 2270 and the consensus.

The first difference relates to upgrading intermediate care facilities (ICFs), the less intensive level of nursing care. Under H.R. 2270, the ICF level would simply be eliminated, with all ICFs having to meeting the higher standards of skilled nursing facilities (SNFs).

The fact is, Mr. Chairman, this proposal would be costly and very difficult for many ICFs to meet.

HCFA data show a $10.36 per day average difference in Medicaid reimbursement rates between SNFs ($49.93) and ICFs ($39.57) in 1985. Now, even if some assurance was given that the Medicaid budget would be permanently increased for this purpose, it must be recognized that only 23 percent of nursing home payments are from the federal Medicaid wallet. Our concern is that states would not increase their Medicaid nursing home payments is well-founded,and wide state-by-state variation in ICF utilization would impose in disproportionate cost burdens. In addition, by upgrading all ICFs to SNFs, the cost impact would be passed on to all other public and private paying patients.

Furthermore, H.R. 2270 does not recognize that other barriers may prevent ICFs from meeting SNF standards, particularly with regard to shortage of nurses and other professionals as well as differences in physical plant standards. Federal mandates are powerful, but not magical.

In contrast, the consensus position agreed to by consumer and provider groups would phase-out the ICF level and replace it with progressive regulatory classifications. The phasing would occur as HCFA and the states implement and fund case-mix systems, which relate a facility's patient care, staffing, and reimbursement levels to the service needs of its patients.

There is not a generic nursing home patient, and there is no generic nursing home. I urge you to be sensitive to the diverse needs of patients and to seek the most advanced techniques for regulating service delivery.

The second major difference from the consensus is the provision in H.R. 2270 requiring greatly expanded federal sanctioning of providers and federal mandates for state sanctioning activities. Certainly, the issue of federal and state enforcement actions was one of the most thoroughly discussed by the consensus groups. Ultimately, the consensus position would require states to have at their disposal an array of enforcement actions and would encourage federal and state agencies to coordinate their enforcement actions. The consensus position also calls on HCFA to give guidance and technical assistance to the states, but drew the line on federal entanglement in state sanctioning. The federal role is to look behind, not to assume state responsibilities.

There is no barrier in federal law that must be removed for states to set up elaborate penalties and procedures; in fact, several states already have such penalties. States find, as did IOM, varied experiences with specific sanctions, and state authority should not be preempted by the federal government. State agencies know best what type of authority they need for their licensing and certification activities and what is their administrative capacity is to execute.

HCFA should be concerned with the policing performance of a state and not the specifics of how it is achieved. Certainly, providers should not be liable for "double jeopardy," that is, sanctions at both the federal and state levels. We believe that federal mandates could tie the hands of state agencies and, in the long run, interfere with the basic goal -- achieving compliance or getting the provider out of the program.

In addition, it would be a particularly inopportune time to be more punitive when a new program for upgrading nursing home quality and regulations is being implemented. Why the preoccupation with that which is already done? Between the wide range of existing federal enforcement weapons and those expected to be approved in the Medicare and Medicaid Patient and Program Protection Act (H.R. 1444), HCFA is well armed.

Before closing, Mr. Chairman, I wish to emphasize the critical relationship between quality of care and reimbursement. Throughout the discussions leading to the consensus, AHCA tried to focus on quality and refrain from raising cost issues, but sometimes it was impossible. If Congress is, indeed, committed to improving quality of long term care, it must be equally committed to providing additional federal resources to cover the cost of additional care and services. Even changes in the survey process will result in increased costs. Facilities inspected by HCFA's revised outcome-oriented survey process report that the deficiencies found when patient care is accurately evaluated can only be corrected with the addition of qualified staff. Without changing a single printed standard, survey teams throughout the country are ordering facilities to increase staff and increase the professional competency of their staff.

Laudable as these quality provisions are, let us not make the mistake of holding out false promises. To enhance there must be recognition that there are costs involved in imposing additional requirements on nursing homes and increasing enforcement activities.

I want to extend to the Subcommittee the assistance of the American Health Care Association in working to implement these important changes in the quality of nursing home patient care.

Mr. WAXMAN. Thank you very much, Mr. Willging.

Mr. Rodgers.

## STATEMENT OF MICHAEL F. RODGERS

Mr. RODGERS. Thank you, Mr. Chairman.

My name is Michael Rodgers. I am a deputy executive vice president of the American Association of Homes for the Aging. AAHA is a national nonprofit organization which represents over 3,200 nonprofit facilities providing health care, housing and community services to more than 500,000 older persons per day.

Seventy-five percent of our homes are affiliated with religious organizations, while the remaining 25 percent are sponsored by various private foundations, fraternal organizations, et cetera.

On behalf of the Association I would like to commend the subcommittee for its continued diligence in seeking to effect positive changes in the current nursing home regulatory system. We are very encouraged to see that the legislation we are meeting about today incorporates so many of the consensus positions outlined in the Campaign for Quality Reform in Nursing Homes, which has been meeting for the past year, and our Association has certainly pledged to support those provisions.

In this context, we would like to briefly comment on some of the sections in H.R. 2270, which our association supports based on the relationship of those provisions to the Campaign for Quality Consensus. I would also like to address a couple of the concerns that we have, and many are noted in our prepared statement.

In the area of resident assessment, AAHA supports the concept of standard resident assessment as a basis to establishment and structure of an individual case plan. Inherent in our support for the establishment of these kinds of assessments is the emphasis that in order to be effective, caution needs to be exercised in the development of any instrument to generate a tool that is both practical and workable.

AAHA recommends that the provisions as outlined in H.R. 2270 calling for the development of a general instrument be amended to require that the Secretary generate a minimum data set of core elements, common definitions and guidelines for utilization. I think that there are a number of excellent examples that have been in use throughout the country today, and we would commend the subcommittee's attention to many of those areas.

In the area of resident assessment, we are concerned with the area relative to the proposed penalty for falsification. While we recognize the intent of this provision and agree that falsification of residents assessment must not be condoned, we believe that given the inherent threat contained in such provisions, some caution needs to be exercised.

Particularly here we are talking about the area of nurses. Since long-term care settings are already at an economic disadvantage when competing in the marketplace for available nursing personnel, enactment of such measure may serve as a further disincentive to accepting employment in a nursing home. AAHA urges that this provision be deleted in favor of an alternative measure such as those that are used in New York State Medicaid Agency and the

RUG system. There, if the State Agency identifies a pattern of inaccurate assessment, the facility is compelled to hire an independent assessment auditor at the facility's expense to perform all assessments for a given period of time.

We believe that such a system on a national level could assure continued efficiency and accuracy in the area of resident assessment.

In the area of nurse aide training, the Association considers the great majority of the requirements in nurse aide training outlined in the legislation to be thorough and practical. We would just simply comment that the allowable rate of reimbursement that equals 50 percent of the training costs perhaps be changed or amended to include some of the consensus papers, some of the consensus documents that talk about 100 percent expended sums for nurse aide training as allowable costs.

In residents' rights, AAHA has long supported the elevation of residents' rights as a condition of participation and is pleased that the legislation would accomplish that goal. The rights set forth in H.R. 2270 recognize that residents' rights extend beyond the basic protections of civil liberties and legal rights to include concepts of quality of care and quality of life.

We have several concerns in the area of residents' rights which we have outlined in our prepared statement.

In terms of Medicaid discrimination, the Association commends the subcommittee for taking an approach to Medicaid access which furthers residents' quality issues in a manner which is achievable by providers. With one exception, we are in agreement with these provisions, and again, we have outlined this in our prepared statement.

Survey and certification process. We are supportive of the provisions in H.R. 2270 designed to improve survey and certification. The Association is particularly supportive of the concept of a trigger mechanism for focusing on facilities which demonstrate poor performance with regard to specific requirements. We believe that the development of a protocol for a standard and extended survey process may prove to be more cost-effective and more efficiently targeting on resources of substandard facilities. At the same time, this approach would also serve as a deserved means of recognition for homes which consistently provide quality care.

Finally, Mr. Chairman, in the area of enforcement, we do have a number of concerns. Certainly from the Association's perspective, we have indicated in our prepared statement that those facilities which present an immediate jeopardy to the health and safety of its residents should not be permitted to continue participating in the Medicaid program until such conditions are remedied. We are in favor of looking at some of the intermediate sanctions but would indicate that we think that those are best achieved and addressed at the State level.

There are other statements in regard to enforcement in our prepared statement, and thank you.

[Testimony resumes on p. 324.]

[The prepared statement of Mr. Rodgers follows:]

Statement by

Michael F. Rodgers, Deputy Executive Vice President,

Policy and Program Implementation

American Association of Homes for the Aging

Mr. Chairman and members of the Subcommittee, I am Michael F. Rodgers, Deputy Executive Vice President, Policy and Program Implementation, of the American Association of Homes for the Aging (AAHA).

AAHA is a national nonprofit association representing over 3200 nonprofit facilities providing health care, housing, and community services to more than 500,000 elderly individuals daily. Seventy-five percent of AAHA homes are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. With strong community involvement and longstanding community ties, AAHA members are committed to meeting the physical, social, psychological, emotional, and spiritual needs of their residents in a manner which enhances residents' sense of self-worth and dignity and allows them to function at their highest level of independence.

On behalf of the Association, I would like to commend the Subcommittee for its continued diligence in seeking to effect positive change in the current nursing home regulatory system. AAHA members share the concern that, unfortunately, quality care is not universally a given in this nation's nursing homes. We believe that the ongoing efforts of this Subcommittee, as evidenced by our presence here today, as well as the additional momentum provided by the recent Senate Finance Committee action justify an optimism that this is the year we will see meaningful Medicaid nursing home improvements effected. These improvements have been the topic of intense discussion by more than 20 provider, consumer, and health professional groups since the publication last year of the Institute of Medicine's report on "Improving the Quality of Care in Nursing Homes." The discussions of these groups, coordinated by the National Citizen's Coalition for Nursing Home Reform, have resulted in consensus positions covering twelve key areas in which the IOM study made recommendations. The consensus documents, published as the "Campaign for Quality Care in Nursing Homes", present a series of workable improvements in the care of this nation's elderly. Significantly, the improvements set forth move away from concerns about facility structures and into affirmative actions for resident quality of life. We are very encouraged to see that the legislation we are meeting about today has incorporated so many of the consensus positions of the Campaign for Quality work group. Our Association is pleased to pledge its support for those provisions.

In this context, I would like to highlight some of those sections of H.R. 2270 which our Association supports, based on the relationship of these provisions to the Campaign for Quality consensus. I would also like to address concerns AAHA has with some areas of the legislation and offer recommendations which we believe will improve these provisions.

Resident Assessment

AAHA supports the concept of resident assessment as basic to the establishment and structuring of individual care plans. Additionally, periodic review provides not only a comparative basis for determining continued appropriateness of a care plan, but also offers a historical perspective to the identification of problematic, or potentially problematic, issues, and thereby aides in the development of therapeutic responses or interventions. Resident assessment is also valuable to nursing home management and regulatory agencies as a tool for determining staffing needs and for providing case mix information for survey and sampling purposes, and ultimately, we hope, reimbursement. Inherent in AAHA's support for the establishment of standardized resident assessment, is the emphasis that, in order to be effective, caution must be exercised in the development of any instrument to generate a tool that is both practical and workable. One attempt at designating a national system, the Patient Appraisal and Care Evaluation (PACE), an assessment tool developed in the 1970's, resulted in a 40 page form which became to unwieldy and complex for practical use. Some states and many individual facilities have already developed comprehensive resident assessment instruments, to be used uniformly within their respective systems, which are linked to reimbursement and survey and certification programs. AAHA recommends that the provision in H.R. 2270 calling for development of a general instrument be amended to require the Secretary to generate a minimum data set of core elements, common definitions, and guidelines for utilization. Some of the existing instruments would be well served as models for conformance into such a system. Examples would include the "Maryland Appraisal of Patient Progress (M.A.P.P.)" utilized throughout the state of Maryland, and the "Resident Functional Assessment Scale (RFAS)", developed by an AAHA member, the Jewish Center for the Aged in Chesterfield, Missouri. RFAS is an assessment tool which as been in use for ten years. A St. Louis University study has found it to be statistically valid and reliable, and it is now computerized. The RFAS utilizes five separate categories, including Activities of Daily Living, Health, Mentation, Behavior, and Motivation, to determine the appropriate pattern of care for each resident. AAHA would further recommend that federal assessment requirements be coordinated with State preadmission screening processes, to the extent possible, to avoid the unnecessary and costly duplication of tests used for diagnostic purposes.

The Association concurs that careful and ongoing assessment of each resident's capabilities to perform daily life functions, to include medical, mental, and psychosocial status, are integral to the provision of quality care. We also support the training of all pertinent personnel in the use of the assessment instrument as essential to ensuring the greatest possible degree of both accuracy and consistency. AAHA recognizes the consideration given to the sufficient time and study afforded for the development of effective standardized assessment and the allowance made for phased-in implementation, and is in agreement that all resident assessments should be coordinated by a registered nurse.

AAHA's remaining concern in the section on resident assessment lies with the proposed penalties for falsification. While the Association recognizes the intent of this provision and agrees that falsification of resident assessments must not be condoned, we believe that given the inherent threat contained in such a provision, some caution must be exercised. Acknowledgement of the existing shortage of available registered nurses among health professionals and related consumer advocate and provider organizations, has been virtually universal. That the demand for registered nurses in the nursing home setting will continue to grow must also be acknowledged in view of the increasing numbers of the aging population, and by the impetus provided by the "quicker and sicker" discharges from acute care settings through the implementation of DRGs. Since long term care settings are already at an economic disadvantage when competing in the marketplace for available nursing personnel, enactment of such a measure can only serve as a further disincentive to accepting employment in a nursing home. AAHA urges that this provision be deleted in favor of an alternate method such as that used by the New York State Medicaid Agency in its RUGs (Resource Utilization Groups) system. There, if the state agency identifies a pattern of inaccurate assessments, the facility is compelled to hire an independent assessment auditor, at the facility's expense, to perform all assessments for a given period of time. AAHA believes that such a system on a national level would ensure an efficient and accurate resident assessment process.

## Provision of Services and Activities

Although AAHA supports 24-hour registered nurse coverage for all intermediate and skilled nursing facilities, we recognize that 24-hour licensed coverage will raise the quality of care in many facilities. We appreciate the possibility of obtaining a waiver for this requirement beyond the 40 hour per week minimum in areas where a shortage of these professionals make recruitment difficult, if not impossible.

## Nurse Aide Training

AAHA recognizes the magnitude of resident care which is provided by nurse aides in nursing homes and acknowledges that this section of H.R. 2270 is of critical importance. The Association considers the great majority of requirements for nurse aide training outlined in this legislation to be thorough and practical. We are highly supportive of the provision that permits facilities with established programs to be able to continue to provide training as long as the programs meet Federal criteria and are approved by the State. Facilities which currently do not have programs established will have the benefit of state-approved programs to develop this training.

The Association would like to express one concern with the provision that prohibits state approval of a program pending the determination of competency of an individual who has completed the program. It appears that this provision requires the state to perform competency testing for nurse aides who have undergone training in a facility during the program's initial period of implementation. It is not clear, however, whether these individuals will retroactively receive appropriate recognition if the training program is approved. The certification status of these employees could therefore be interpreted to be questionable. AAHA believes that since these "first-time" trainees also run the risk of not receiving certification by virtue of the program being denied approval, this intent should be clearly stated.

Finally, AAHA would like to comment on the allowed rate of reimbursement to equal 50% of the training costs. We would like to refer here to the Campaign for Quality Care consensus document, which requires Medicaid to include 100% of the sums expended for nurse aide training as an allowable cost. AAHA considers the issue of nurse aide training to be one of the most important provisions this legislation will accomplish. It is critical to its success that sufficient funding be allocated to permit the development of training programs of the highest caliber possible.

Resident Rights

AAHA has long supported the elevation of residents' rights to a condition of participation and is pleased that this legislation would accomplish that goal. The rights set forth in H.R. 2270 recognize that residents' rights extend beyond the basic protection of civil liberties and legal rights to include the concepts of quality of care and quality of life. AAHA's own work in this area, beginning with a Patient Bill of Rights developed in 1975, has emphasized numerous residents rights including, but not limited to, resident entitlement to informed and confidential health care, the right to participate in decision making through resident councils and other means; the right to safe, secure, and aesthetically tasteful environment; the right to privacy and confidential communication; and the right to manage personal finances. AAHA publications such as Social Components of Care, identifying those physical or program arrangements which encourage residents to maintain themselves as individuals with personal dignity and as members of the community, and Resident Decision Making in Homes for the Aging, a step-by-step guide to starting a resident council or improving an existing one have been targeted to nursing home administrators, as well as the general public.

Most recently, AAHA, with the support of Peat, Marwick, Mitchell & Co., has published a series of consumer brochures to help elderly individuals better understand the variety of housing, services, and care options provided by AAHA members. We are attaching the brochure entitled, "Choosing a Nursing Home: A Guide to Quality Care", which provides a list of items to look for when considering a specific nursing home. A facility's commitment to residents' rights and resident participation is, of course, included in the check list.

The Association has two concerns with the resident rights section of H.R. 2270. The first is the provision which calls for annual, independent, external review of any resident receiving psychotrophic drugs. We believe that clarification is required regarding the qualifications of this person, and how his or her observations are to be reconciled with those of the facilities' own consulting pharmacists, the attending physician, and the surveyors. We are also curious about the manner in which this individual is to be compensated for services which appear to be highly duplicative.

Our second concern involves resident transfer rights, specifically the provision which requires facilities to establish procedures for residents whose medical leave has exceeded the time period allowed under the bed-hold provisions of the State plan. AAHA opposes this section as contradictory to the quality of life and quality of care thrust of this legislation. A requirement of this nature has the potential to result in practice as a "swinging door" policy, thus creating a climate of uncertainty, disruption, and instability for the resident in question, for the residents remaining in the facility, and for the provider. Questions which must be raised include the type of discharge planning that will have to occur from an acute care perspective. If the original facility cannot readmit the resident, the hospital discharge planners are faced with developing a plan which may eventually encompass several transfers before the resident can return to his/her original facility. In addition to the problems faced with discharge planning, long term care facilities face the difficulties in care planning associated with holding residents awaiting space in their original home. The effects on the resident of possible multiple transfers, and the ramifications for potential first admissions are factors which must also be addressed. The provision does not indicate whether "return admissions" would take precedence, but one implicit consequence would be a reduction in availability of space for first-time admissions.

Access and Visitation Rights

AAHA favors access to and visitation by all professionals, family members, and others who can make resident's stay safer, healthier, happier, and more productive. We are in general agreement with the access and visitation provisions of H.R. 2270, but would ask for one modification of the provision which grants immediate access to any representative of the Secretary, state, or ombudsman. In accordance with the consensus document referenced earlier, we would like the term "offically designated" inserted before the word "respresentative." This is a seemingly small matter; however, given the number of individuals who alledgedly represent the Secretary or State, we feel it is essential to have some means of controlling traffic within the facility, particularly during the night hours.

## Medicaid Discrimination

The Association commends the Subcommittee for taking an approach to Medicaid access which furthers resident quality issues in a manner which is achievable by providers. With one exception we are in agreeement with these provisions. The exception lies in the prohibition of third party guarantors of payment. We agree that once Medicaid eligibility has been established, these guarantors should not be permitted. However, until eligibility is established, the provider needs some protection against non-payment. This is particularly true where the resident's eventual ineligibility for Medicaid is due to the resident's own behavior, i.e., illegal transfer of assets. We recommend that the Subcommittee adopt the Campaign for Quality solution to this problem by providing for up to two months of Medicaid coverage while eligibility is being determined.

## Pre-Admission Screening and Annual Resident Review for Mentally Ill and Mentally Retarded Residents

AAHA has made the decision to reserve comment on the provisions in H.R. 2270 which pertain to requirements for preadmission screening and annual resident review for mentally ill and mentally retarded individuals. The Association believes that these are provisions which warrant further examination and exploration with our members. We respectfully request the opportunity to comment on these issues at a later date.

Survey and Certification

AAHA is supportive of provisions in the H.R. 2270 designed to improve the survey and certification process for nursing homes. The Association particularly supports the concept of a trigger mechanism for focusing on facilities which demonstrate poor performance with regard to specified requirements. AAHA believes the development of a protocol for a standard and extended survey process may prove to be more cost effective by more efficiently targeting resources on substandard facilities. At the same time, this approach would also serve as deserved means of recognition for homes which consistently provide quality care.

AAHA recognizes the apparent conflict of interest in using a surveyor who is currently also serving as consultant to one or more facilities to help the facilities achieve compliance for nursing home certification. However, the Association believes that prohibiting the employment of individuals as surveyors who have a consultative history occurring within the past two years is overly restrictive and may prove disadvantageous. Such a two-year ban on hiring would deny states the opportunity for recruiting individuals for surveyor positions who have an indepth understanding of the functioning of a nursing home, as well as the regulatory system. The Association recommends that the provision be amended to prohibit a former consultant from being sent to a specific facility for which the individual has provided consultation services.

AAHA also continues to be concerned about the provision which would reduce federal payments to States with inadequate state survey performance. We believe there is general agreement that state budgets are strained and that many states are already uneasy about the adequacy of their survey budgets. A reduction in payment for poor performance can only serve to intensify the performance problems, and can result in scheduling difficulties as well. If survey and certification budgets are penalized, some facilities could remain unsurveyed, endangering their participation in the Medicare and Medicaid programs. This is ultimately a consumer issue; facilities which are not Medicare and/or Medicaid certified cannot provide access to Medicare and/or Medicaid residents.

The importance of having timely and well-conducted surveys is the reason AAHA, along with the other participants of the Campaign for Nursing Home Quality, is advocating 100% federal funding for the costs of nursing home survey and certification for five years. The Federal role in protecting nursing home residents and assuring quality care cannot be minimized. The growing need for a tangible commitment to this role has recently been evidenced in the increased burden placed on states through implementation of the new Long Term Care Survey Process (PaCS). The Association views PaCS, with its shift in focus from paperwork compliance to patient care, as a crucial step toward achieving consistent, reliable assessment of quality of care. Sufficient funding for nursing home survey and certification activities is inextricably tied to ensuring this opportunity for success.

In addition to restoring the 100% federal funding level, we request that the

Subcommittee reconsider the provision which would allow the Secretary after 1993, the option of limiting the sums found to be necessary for a state's nursing home survey and certification activities, based on 100 percent of the mean of the survey costs per bed for all states. While recognizing government's concern about limiting federal expenditures, AAHA suggests that use of this formula as it stands may result in creating a disincentive for those states which are currently performing optimally, as well as efficiently; we believe that this quantitative assessment may be misleading. The Association suggests that, in and of themselves, lower or higher expenditures by a state compared to all states may not always provide an accurate measure of regulatory agency activities; external factors, such as rural locations where transportation costs are high for surveyors and/or regional variations in prevailing wage rates may influence the cost of a state's survey and certification activities. In addition, some states may currently be spending an inadequate amount on survey and certification and thus, the mean derived could underestimate the amount necessary for this activity. Therefore, AAHA recommends that an allowable percentage be determined, e.g., within 125% of the mean costs, under which states would be funded at a 100 percent of their costs without review. Finally, for those states with survey costs in excess of 125% of the mean, we would suggest that the optional review, if utilized, include justification and analysis of a state's total costs, against such known factors as wage rates and transportation costs, in order to determine if a state is "inefficient" or is spending more than other states legitimately.

Finally, AAHA has one remaining concern with the provision requiring notice to the attending physician and the Nursing Facility Administrator Licensing Board. While we agree in concept with this provision, we believe the term "poor quality" to be subjective and in need of further elaboration. The provision does not qualify the criteria for notification in terms of severity or frequence of noncompliance. We recommend amendment to require notification to these entities in instances of noncompliance severe enough to warrant sanction activity.

## Enforcement

AAHA concurs that facilities demonstrating conditions which have been determined to "immediately jeopardize the health and safety of its residents" should not be permitted to continue participating in the Medicaid program until such conditions are rectified. The Association is also supportive of the use of intermediate sanctions as an alternative to termination as the sole recourse in responding to substandard conditions where "immediate jeopardy" does not exist. AAHA continues to believe that the issue of intermediate sanctions would best be addressed at the state level. However, the Association's primary concern with the implementation of both federal and state alternative sanctions has centered on the existing lack of a mechanism assuring communication between federal and state agencies. These sanctions could therefore be applied concurrently, placing the facilities in a position of "double jeopardy", and creating the potential for effective termination in the name of an intermediate response. AAHA recognizes the intent to remedy this situation through the "Special Rules" provision, providing guidelines when the State and Secretary do not agree on a finding of noncompliance.

The Association would like to restate our position that the $10,000/day fine allowed as a federal alternative sanction for noncompliance is excessive. The impact of imposing a civil penalty in such a large amount will likely result in a swift, if not immediate, crippling of a facility's capability to continue operations.

## Conclusion

The issues of affording elderly individuals access to quality care in nursing homes, with reimbursement that reflects the true cost of providing this care, are top priorities for AAHA. The Association strongly supports the elevation of residents' rights to a condition of participation, the concept of standardized, comprehensive resident assessment, the more efficient targeting of resources on substandard facilities, and increased federal funding for nursing home survey and certification activities. We believe that voluntary agencies play a vital role in the initiatives and provision of services to the elderly, but, that the Federal Government must also play a key role in responding to the needs of the aging in our society.

AAHA again commends the Subcommittee for its efforts to effect positive change in the nursing home regulatory system and extends its appreciation for the opportunity to present the Association's views and comments on the proposed legislation.

# American Association of Homes for the Aging
# Bill Of Rights

## Preamble

THE DIGNITY OF THE INDIVIDUAL IS NEVER MORE IMPORTANT -- AND NEVER MORE IN DANGER -- THAN IN OLD AGE. WITH ITS TRADITIONAL CONCERN FOR THE OLDER PERSON, THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING BELIEVES THAT RESIDENTS IN ITS MEMBER HOMES ARE NOT ONLY ENTITLED TO HIGH STANDARDS OF SOCIAL AND PHYSICAL CARE, BUT ALSO TO THE EXERCISE OF THOSE INHERENT HUMAN RIGHTS THAT CONTRIBUTE TO THE TOTALITY OF INDIVIDUAL DIGNITY.

TO EMPHASIZE THIS BELIEF, THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING RECOMMENDS THIS "BILL OF RIGHTS" FOR RESIDENTS (MEANING ALL WHO RECEIVE CARE IN OUR FACILITIES, WHETHER CALLED PATIENTS, BOARDERS OR MEMBERS), IN THE HOPE THAT IT WILL CONTRIBUTE TO THEIR PHYSICAL AND MENTAL WELL-BEING, TO THEIR OPPORTUNITIES FOR CONTINUED PERSONAL GROWTH, AND TO THE REAFFIRMATION OF THEIR HUMANITY.

## Bill of Rights

THE RIGHTS OF A RESIDENT FALL INTO SEVERAL CATEGORIES. IN EACH, HOWEVER, THE OLDER PERSON RETAINS ONE OVERRIDING CLAIM, THAT IS, HIS OR HER RIGHT TO BE TREATED IN ALL RESPECTS AS AN INTELLIGENT AND SENSITIVE HUMAN BEING. THE OLDER PERSON HAS THE RIGHT TO RELIGIOUS AND CIVIL LIBERTIES; AND TO THE WIDEST POSSIBLE FREEDOM OF CHOICE AND DECISION CONSISTENT WITH THE STANDARDS, RIGHTS AND OBLIGATIONS OF THE HOME.

## Personal Rights

THE RESIDENT HAS THE RIGHT TO COURTEOUS AND EQUAL CONSIDERATION FROM ALL WITH WHOM HE OR SHE COMES IN CONTACT.

THE RESIDENT HAS THE RIGHT TO CHOOSE AMONG THE VARIOUS OPTIONS FOR PERSONAL PRIVILEGES PROVIDED BY THE HOME. HE OR SHE ALSO HAS THE RIGHT TO EXPECT THAT FACILITIES ENHANCING PERSONAL NEEDS WILL BE MADE AVAILABLE.

THE RESIDENT HAS THE RIGHT TO PRIVACY; TO CONFIDENTIAL COMMUNICATION BY MAIL AND TELEPHONE, INCLUDING THE RIGHT OF CONFIDENTIAL COMMUNICATIONS WITH HIS OR HER ATTORNEY.

THE RESIDENT HAS THE RIGHT TO KEEP WITH HIM OR HER A REASONABLE NUMBER OF PERSONAL MEMENTOS.

THE RESIDENT HAS THE RIGHT TO EXPLORE THE LIMITS OF HIS OR HER POTENTIAL FOR PERSONAL GROWTH, IN TERMS OF INTERPERSONAL RELATIONSHIPS, OPPORTUNITIES FOR SERVICE IN THE COMMUNITY, AND OPPORTUNITIES TO REVITALIZE OLD SKILLS OR DEVELOP NEW ONES AND CHANNEL THEM INTO CREATIVE CURRENT USES. HE OR SHE HAS THE RIGHT TO EXPECT THAT PHYSICAL, PSYCHOLOGICAL AND SPIRITUAL COUNSEL AND GUIDANCE WILL BE AVAILABLE TO HELP ACHIEVE THIS GROWTH.

THE RESIDENT HAS THE RIGHT TO HAVE HIS OR HER SUGGESTIONS CONSIDERED BY STAFF AND ADMINISTRATORS THROUGH MEDIA SUCH AS RESIDENTS' COUNCIL, AND THE RIGHT TO PRESENT GRIEVANCES WITHOUT FEAR OF REPRISAL.

THE RESIDENT HAS THE RIGHT TO MANAGE HIS OR HER OWN FINANCES.

THE RESIDENT HAS THE RIGHT TO THE SAME DIGNITY IN DYING AS IN LIVING.

## Environmental Rights

THE RESIDENT HAS THE RIGHT TO SAFE PHYSICAL ACCOMMODATIONS AND ENVIRONMENT. WHEREVER REASONABLE, THIS SHOULD INCLUDE AESTHETICALLY TASTEFUL SURROUNDINGS IN ADDITION TO THE BASIC AMENITIES, AND THE PROVISION OF AREAS FOR PERSONAL SOCIALIZATION AND FOR ENTERTAINING FAMILY AND FRIENDS.

THE RESIDENT HAS THE RIGHT TO PHYSICAL SECURITY. THIS INCLUDES ADEQUATE PROTECTION AGAINST NATURAL DISASTERS SUCH AS FIRE AND STORM, AND THE RIGHT TO SECURE STORAGE SPACE FOR PERSONAL BELONGINGS.

## Health Rights

THE RESIDENT HAS THE RIGHT TO HEALTH CARE, INCLUDING: FULL INFORMATION REGARDING HIS OR HER MEDICAL CONDITION, DIAGNOSIS AND TREATMENT (UNLESS MEDICALLY CONTRAINDICATED); PROMPT CARE BY QUALIFIED AND COMPETENT PERSONNEL; PRIVACY DURING CARE AND CONFIDENTIALITY OF ALL MEDICAL RECORDS CONSISTENT WITH ADEQUATE TREATMENT THE RIGHT TO RETAIN A PERSONAL PRIVATE PHYSICIAN FOR PURPOSES OF CONSULTATION WITH STAFF DOCTORS.

THE RESIDENT HAS THE RIGHT TO BE FREE OF PHYSICAL OR CHEMICAL RESTRAINT, EXCEPT WHEN MEDICALLY AUTHORIZED.

THE RESIDENT HAS THE RIGHT TO GIVE OR WITHHOLD INFORMED CONSENT FOR NON-EMERGENCY TREATMENT AFTER THE IMPLICATIONS OF THAT CHOICE HAVE BEEN EXPLAINED.

- A policy that encourages residents to go outside. Even city homes should have a lawn or garden area for residents to get fresh air.
- A physician who is available for emergencies.
- An activity room or designated space for residents who are able to be involved in reading, craft work, or interesocial activity such as card games.
- A friendly and available staff who appear pleasant, caring, and accommodating to residents and visitors.
- A volunteer program.
- An active resident council or some type of resident participation program that enables residents to recommend changes within the home.
- A residents' bill of rights or a stated policy that identifies and respects residents' individual rights.

## What Terms Should You Understand as You Search for a Nursing Home?

**Chronic illness** – A physical or mental disability marked by long duration or frequent recurrence.

**Intermediate care facility (ICF)** – A nursing home offering personal care and help with daily living activities, along with less intensive nursing care than a skilled nursing facility, to those unable to live independently yet not in need of round-the-clock nursing care or supervision. Some areas refer to ICFs as health related facilities (HRFs).

**Long-term care** – The provision of services to persons of all age groups, but primarily the elderly, who suffer from chronic health impairments.

**Medicaid** – The federal/state health care financial assistance program for people with limited income.

**Medicare** – The federal health insurance program for citizens age 65 or older who are in need of skilled or intensive rehabilitative care. It provides only partial payment for a maximum of 100 days of skilled nursing care in a certified facility, following a hospital stay of three or more days. Certain restrictions may end Medicare eligibility before 100 days have passed.

**Skilled nursing facility (SNF)** – A nursing home that provides 24-hour care, rehabilitation programs, and other specialized services under the supervision of a registered nurse for chronically ill and disabled elderly.

## Where Can You Get Additional Information?

- Contact AAHA to find out if your state has an AAHA affiliate. AAHA affiliated state associations operate in 37 states around the country.

  American Association of Homes for the Aging
  1129 20th Street N.W., Suite 400
  Washington, DC 20036
  202/296-5960
- Ask your local or state health department for a list of nursing homes in your area. Your Social Security office maintains a list of homes approved for Medicare.
- Your county social services department will have a list of homes approved for Medicaid.

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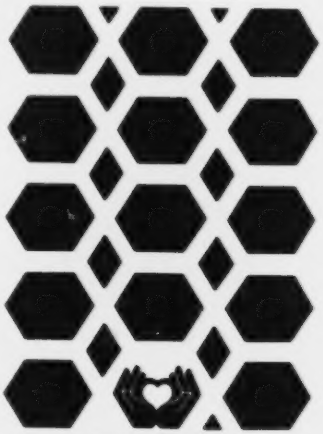
# CHOOSING A NURSING HOME

## A Guide to Quality Care



AMERICAN ASSOCIATION
OF HOMES FOR THE AGING

### Should You Consider a Nursing Home?

Do you have an elderly relative who can no longer live independently? Does he or she need 24-hour care and supervision? Is this person chronically ill, yet not sick enough to require the intensive care a hospital provides? Does your relative need help with daily living activities such as bathing, dressing, toileting, eating, and walking?

If you answered yes to most of these questions, then you and your relative probably have reached the point where you should consider a nursing home.

### What is AAHA?

For a quarter century AAHA, the American Association of Homes for the Aging, has been the national organization of not-for-profit nursing homes, senior housing, continuing care retirement communities, and community services for the elderly. AAHA's members are community-supported facilities sponsored by religious, fraternal, labor, private, and government organizations to provide quality services for their residents and for older people in the community at large.

Nonprofit care and service for the elderly has been a vital force in our nation since its founding. Many AAHA members have served older persons' needs for over a century.

AAHA used its expertise in care and service to the elderly to create this guide to help you and your relative locate a nursing home that best meets your mutual needs.

### What is a Nursing Home?

A nursing home is a facility which provides care at different levels for elderly people who can no longer live independently because of physical or mental debilitation, emotional trauma or chronic illness.

### What Kinds of Services Can a Nursing Home Offer?

A quality nursing home offers a full array of personal, dietary, therapeutic, social, pastoral, recreational, and nursing services. Meals, laundry, housekeeping, and medical services are provided. In addition, most not-for-profit homes offer religious services, recreational activities and counseling programs.

### Who are the Providers of Primary Services in a Nursing Home?

The **board of trustees** in a nonprofit home determines general policies the home will follow to implement its mission of care and service to the *total person*. Trustees are volunteers who often are leaders of the local community.

The **administrative staff** is responsible for the day-to-day planning and operation of the home. Personnel usually include an administrator or executive director, and admissions, personnel and financial directors.

**Nursing staff** offers daily care to residents. The director of nursing usually is a licensed registered nurse who manages the daily activities of other RNs, licensed practical nurses (LPNs), and nursing assistants.

**Therapists** provide, among other services, physical, occupational and speech therapy programs directed to specific disabilities of the residents.

The **medical director** is a physician appointed to help ensure the adequacy and appropriateness of the medical services provided to residents. A consultant medical staff will also make available psychiatric care and various medical specialties.

The **activities coordinator** is a trained therapist or someone designated to assess residents' individual needs and create programs that provide recreation and entertainment as well as therapy to compensate for weaknesses.

**Social service staff** consists of social workers and perhaps psychologists and counselors who assist residents in coping with the emotional and psychological aspects of aging.

The **food service director** oversees a nursing home's daily meal program. Many homes also employ a consulting dietitian to ensure that meals are appetizing and varied and meet the individual dietary requirements of residents.

**Pastoral care staff** consists of ordained, professional or lay persons trained to meet the spiritual needs of residents through worship, study, meditation and pastoral counseling.

**Volunteers** are members of the community who assist staff by spending many hours interacting with residents and helping them perform their daily activities.

### Who Pays for Nursing Home Care?

Nursing home care, like all good health care, is costly. Before you agree to pay for services, understand completely all the financial arrangements of the home you have selected. Nursing homes charge a basic daily or monthly rate.

Many residents or their families pay for nursing home care out of their own private funds. Others whose finances are depleted rely on Medicaid to cover the costs of their nursing home care.

Ask admissions staff at the nursing home of your choice what the basic monthly fee is and what it includes. Ask if the home charges extra for physicians' fees, medications, laundry, special feeding, frequent linen changes, or special supplies such as wheelchairs and walkers. Are therapies included in the [illegible] Is a deposit required?

To find out whether a resident is eligible for Medicaid, call the Department of Social Services in your area. Contact your Social Security office about Medicare.

The nursing home will ask for financial disclosure to determine the appropriate payment mechanism. Admissions personnel will assist you in determining what information is necessary and what forms need to be filed to expedite placement.

Because waiting lists can be long for admission to a nursing home, you might want to have paperwork done in advance in the event that an emergency placement needs to be made.

### What Does Every Good Nursing Home Have?

- A current operating license from the state.
- An administrator who has an up-to-date state license.
- Certification for Medicare and Medicaid if these programs are important to you now or in the future.
- A location that suits the resident and makes regular visits by family and friends possible.
- Handrails in hallways and grab bars in bathrooms, and other features aimed at accident prevention.
- Clearly marked exits and unobstructed paths to these exits. Also, doors unlocked from the inside and enclosed stairways. All nursing homes must comply with federal and/or state fire safety codes.
- Bedrooms that open onto a corridor and have windows, as required by law.
- No heavy odors, whether pleasant or offensive. A good home will not use highly scented sprays to mask odors.
- Hallways wide enough to accommodate two wheelchairs to pass with ease and wheelchair ramps for easy access into and out of the home.
- Kitchens that separate food preparation, garbage and dishwashing areas and keep perishable foods such as milk, cream sauces and mayonnaise refrigerated.
- Toilet facilities designed to accommodate wheelchair residents.
- An attractive resident dining room with tables convenient for wheelchairs and food that looks appetizing. Notice, too, whether residents who need help are receiving it.
- Residents who look clean and are dressed appropriately for a full day of activity and social interaction.

Mr. **Waxman**. Thank you.
Mr. Baxter.

### STATEMENT OF RAYMOND J. BAXTER

Mr. **Baxter**. Mr. Chairman, I am Raymond J. Baxter on behalf of the Health and Hospitals Corporation of New York City, and we thank you for this opportunity comment on the bill today and to express our strong support for its provisions.

HHC has the unique vantage point that we are the largest municipal health care system in the Nation. We operate 11 acute care hospitals, 40 community based ambulatory care centers, the city's emergency medical service, and 5 long-term care facilities. Our facilities contain nearly 2,500 SNF and ICF level beds and include the longest—the oldest long-term care hospital in the Nation, Coler Memorial Hospital.

We also provide six certified home health agencies, extensive inpatient and outpatient chronic care and rehabilitation services, and our plans call for a major expansion of home care services and nearly 1,000 additional long-term care beds in the coming years.

HHC has a longstanding commitment to the provision of long-term care. An integral part of our mission is to provide a full continuum of high quality services to the people we care for. We have an extensive quality assurance program and a system of resident advocates within each of our institutions. We play a special role in serving those persons with multiple disabilities, enduring high levels of care needs, limited financial and social resources, and inadequate access to other sources of care.

We also serve not only the elderly, but a relatively young population as well. In fact, 32 percent of our long-term care patients are under the age of 65.

There are a number of factors in the long-term care environment that have shaped the development of our policies—the historic limitations on supply and on access, particularly the limitations on access to long-term care due to restrictive program eligibility requirements, poor insurance coverage, and discriminatory admissions practices and gaps in services.

At the same time, demand has increased. The growth of a younger population has been a particular problem for HHC, which, as I noted earlier, is one of the few long-term care providers focusing on younger as well as older persons.

For these reasons, we believe the Medicaid Nursing Home Quality Care Bill is so important. Nursing homes must be required to provide all the necessary assurances for patient rights, quality of care, quality of life, patient assessment and care plans, and adequate nursing, physician, and rehabilitative services.

This bill is, in general, consistent with the regulations in New York State and the practices within HHC under which we have been operating for the last several years. We believe these regulations have been instrumental in improving the quality of long-term care in New York State, and we support them fully.

The following issues in this bill deserve some attention:

The bill removes the distinction between SNF and ICF levels of care. This is a positive development. The differentiation between

SNF's and ICF's has been an ongoing and somewhat specious debate in long-term care. The reality has been that residents have changing needs, and at any point, both SNF's and ICF's may have patients with a similar range of nursing and rehabilitative needs. We believe that the same quality assurance measures should be provided for all of those residents.

And while it is important that the bill provide or require state's to provide adequate reimbursement for the additional costs that may be involved in upgrading these services, it is also important that they be required to closely monitor admission and discharge practices to avert any gaming of the system that may occur based on the inherent incentives.

Monitoring provisions would strengthen the sections outlining resident's admission and transfer rights. Although the permissible reasons for involuntary transfer or discharge are clearly defined in the bill, there remains the potential for dumping certain kinds of patients. Patients with behavioral problems and minorities, for example, are examples of persons who have difficulty being placed in nursing homes in the first place and who, in many instances, facilities do not want to retain.

Another example relatively new is the person with AIDS. HHC's long-term care AIDS program, one of the first in the Country, includes 24 long-term care AIDS bed last year and will more than double to 52 beds this year. This is a growing population that cannot be ignored and provokes a unique set of needs and problems which most long-term care facilities have so far been unwilling to address.

For all of these reasons, the provisions of the bill regarding access, admission, and transfer, we urge be as stringent as possible.

Finally, the bill requires a standard Federal protocol for surveys. We believe that this provision should be amended to permit States to use their own protocols, so long as they are approved by HHS as meeting or exceeding Federal standards.

In conclusion, as our population continues to age, the Medicaid program faces increasing pressures to provide for more of the Nation's long-term care needs with limited resources. We urge that the Federal Government also address the larger issue of access to quality long-term care services, including the expansion of Medicare coverage for long-term care, both institutional and community-based, as well as reimbursing providers adequately for special populations such as the AIDS patient, the person with behavioral problems, the persons with Alzheimer's.

Integral to those important next steps is the assurance of quality of care for all patients currently in nursing homes. This bill takes a major step in providing that assurance for this population. We applaud and welcome the committee's efforts and those of you, Mr. Chairman, to enhance the quality of care in our Nation's long-term care facilities, and we would be proud to work with you in finalizing this bill and working with you on future long-term care issues.

[The prepared statement of Mr. Baxter follows:]

STATEMENT OF RAYMOND J. BAXTER

Thank you for this opportunity to testify on the Medicaid Nursing Home Quality Care Amendments of 1987. As a major public provider of long-term health care services, the New York City Health and Hospital Corporation (HHC) strongly supports this bill which addresses the critical issues of quality of care for Medicaid patients in nursing homes.

HHC is the largest municipal health care system in the Nation comprising 11 acute care hospitals, 40 community-based ambulatory care centers, the city's emergency medical services and 5 long-term care facilities. HHC's long-term care facilities have nearly 2,500 SNF and HRF (ICF) level beds. Our long-term care system includes the oldest long-term care hospital in the Nation, Coler Memorial Hospital, a hospital-based SNF, six certified home health agencies, extensive inpatient chronic care and rehabilitation services and a broad array of geriatric and geriatric-psychiatric outpatient services. Our current plans call for a major expansion of home care services and adding nearly 1,000 long-term care beds. In addition to being one of the largest and most diverse long-term care providers in New York City and State, HHC also discharges thousands of patients each year to non-HHC long-term care institutions.

HHC has longstanding and ongoing commitment to the provision of long-term patient care. An integral part of our mission is to provide a full continuum of health services to the people we serve. We play a special role in serving those persons with multiple disabilities, enduring high level of care needs, limited financial and social resources, and inadequate access to other sources of care. Interestingly, we also serve a relatively young patient population. In fact, 32 percent of our long-term care patients are under age 65.

There are a number of changes and problems in the long-term care environment that have affected the development of our policies at HHC. The supply of both institutional and community long-term care services is limited by regulation, costs, and historic lack of financial incentives to care for long-term care patients with more complicated needs. In addition, access to long-term care is limited by program eligibility requirements, poor insurance coverage, discriminatory admission practices and gaps in services.

At the same time, the demand for services and there is increased competition for limited long-term care capacity. In particular, there has been a significant growth of a younger population requiring long-term care for extended periods of time, further increasing competition for the limited supply of beds. This is special problem for HHC which is one of the few providers willing to serve young disabled people. It is for these reasons that the Medicaid Nursing Home Quality Care bill is so important. Nursing homes should be required to provide assurances for patient rights, quality of life, patient assessment and care plans, and adequate nursing, physician and rehabilitative services.

In general, the bill is consistent with current New York State regulations and practices under which the HHC has been functioning. We believe such regulations have been instrumental in improving the quality of long-term care in New York State. The following issues in the Quality Care bill do, however, deserve attention.

The bill removes the distinction between SNF and ICF levels of care. This is a positive development. The differentiation between SNF's and ICF's has been and ongoing debate in long-term care. These two classes of long-term care were intended to separate residents with differing levels of nursing needs. The reality has been that residents have changing needs and, at any point, both SNF's and ICF's may have patients with a similar range of nursing and rehabilitative needs. This provision of the bill would basically require that quality assurance measures be the same for both types of facilities. It is important that the bill require States to provide adequate reimbursement for the additional cost of the upgrade in services and that they remove the existing restrictive reimbursement of ICF's. States should also be required to closely monitor those patients discharged from ICF's in order to avoid "dumping" lower level of care patients out of ICF's in favor of patients with higher levels of reimbursement. Monitoring provisions are also needed for the sections outlining the resident's transfer rights. Although the permissible reasons for involuntary transfer or discharge are clearly defined in the bill, there is once again the potential for "dumping" patients. Psychiatric patients, patients with behavioral problems and minorities are examples of patients who have difficulty being placed in nursing homes and who in many instances are patients the facilities do not want to keep. Another example is the AIDS patient. HHC's long-term care AIDS program, one of the first in the Nation, is administered by interdisciplinary teams. We current operate 24 long-term care AIDS beds and plan to expand to 52 beds in fiscal year 1988. This growing patient population presents a unique set of needs and problems which many long-term care facilities are unwilling to handle, thereby leaving the patient vulnerable to dumping.

Finally, the bill requires a standard (Federal) protocol for surveys. This provision of the bill should be amended to permit States to use their own protocols, as long as they are approved by the Department of Health and Human Services.

As our population continues to age, the Medicaid program faces increasing pressures to provide for more of the Nation's long-term care needs with fewer resource. HHC urges the Federal Government to address the issue of access to quality long-term care services by expanding Medicare coverage for long-term care as well as by adequately reimbursing providers for care of special populations such as AIDS patient, the homeless, and Alzheimer's patients. Integral to those important next steps in the assurance of quality of care of patients currently in nursing homes. The Medicaid Nursing Home Quality bill takes a major first step in providing that assurance for the population needing long-term care. We applaud and welcome the committee's efforts to enhance the quality of care in our Nation's nursing homes and would be pleased to work with you in finalizing this bill and or future long-term care issues.

Thank you. I will be happy to respond to your questions.

Mr. **Waxman**. Thank you very much, Dr. Baxter.

Mr. Kerschner.

## STATEMENT OF PAUL A. KERSCHNER

Mr. **Kerschner**. Mr. Chairman, thank you very much. I am Paul Kerschner. I am executive director of the American Medical Directors Association, which represents 7,000 physicians, both medical directors and attending physicians, that work in long-term care facilities.

In consideration of time, Mr. Chairman, I will submit my written comments, and I'd like to concentrate on a few issues that I have raised and also that were raised here this morning. And the one is, I think we have to acknowledge how far the nursing home industry has come.

Fifteen years ago when I was executive director of the Maryland Governor's Commission on Nursing Homes, wherein 36 people died of Salmonella in a Baltimore City nursing home, we found issues that were serious and varied—noncertified and ill-trained administrators; uninvolved and nongeriatrically trained physicians; untrained and unappreciated nurse's aides; biased and complacent surveyors; and inadequate reimbursement. In short, 15 years ago, this was an industry in trouble.

Contrast those dark days with the present environment: administrators who are licensed, certified, and responsible for hours of continuing education; physicians who derive from family practice programs, who are trained in geriatrics and have become key actors on the long-term care team; nurse aides who are required by many States or facilities to participate in training programs which include competency examinations; surveyors who are far better trained and who have a survey instrument, which for the first time provides for direct patient assessment rather than paper compliance; and a reimbursement system which is currently under review by policymakers knowledgeable as to the resources required to insure quality of care.

So we have a different industry, Mr. Chairman. On the other hand, there are still problems, and some of those problems I would like to address.

The first is nurse aid training. In a survey that my foundation recently conducted, we found out that turnover for nurse aides runs across the country anywhere from 90 to 300 percent, depending on the location of the facility. If you look at the salaries of nurse aides, the average salary is $3.75 an hour. McDonald's pays $4; Pizza Hut pays $4.25 plus tips. So the issue of money for nurse aides is clearly an issue, but it's not the only issue.

There are issues of status. There are issues of career ladders, and we need to address this, and I applaud you for your nurse training provisions—nurse aide training provisions.

I would urge that this be a national program, that there be a national training and certification program, which could be administered nationally, so that if nurse aides or indeed even patients cross State lines, there is some continuity of the training and of the testing, and I think that with your help and the help of HCFA, we could determine a national certification and training program for nurse aides.

Second, one of the members that was not mentioned here very much in the questioning is the role of the medical director and attending physician in the facilities. We are now seeing facilities that have ventilator-dependent children, AIDS victims, DRG so-called subacute or super-skilled patients, brain-damaged adults. This is a very different patient mix, and we need to assure that the physician plays a major role in that facility. If it takes higher reimbursement to get the best and the brightest to operate in those facilities, perhaps $8 or $9 or $10 per visit is not enough; maybe we should look at $16 to $20. But in addition, we need to make the physician responsible. We need to do the same thing for the physician that we're doing for the administrator and the rest of the staff—that is, PAC him, make him part of the PAC process, so that you begin to look at the care being provided, rather than issues of whether or not he signed off on an order every 48 hours. We need to look at the care that's being given at the bedside.

Let me also talk a little bit about the intermediate—the combining of intermediate and skilled care. I suggest to you, that's going to be a severe problem for the small, rural ICF facility, which does not have the resources to meet the skilled standard, and yet is providing a terribly needed service at the local level.

I agree. I think it's—if ever, the levels of care's time was ever there, it is long past. We need to get rid of those levels of care. But I suggest we do it through an acuity-based patient mix reimbursement system, and I suggest that you join with your colleague, Mr. Chairman, on the Senate side, develop a long-term care commission, whose first role would be to develop a patient mix reimbursement system that would then, once and for all, do away with the levels of care, based the reimbursement on the acuity of the patient's illness, rather than try to integrate intermediate and skilled care, because I think it's going to wreak hardship on many facilities across the country.

Once again, Mr. Chairman, I appreciate the opportunity to testify, and I'd be happy to answer questions.

[The prepared statement of Mr. Kerschner follows:]

### STATEMENT OF PAUL A. KERSCHNER

Good Afternoon, I am Paul Kerschner, Executive Director of the American Medical Directors Association (AMDA) and President of the National Foundation for Long Term Health Care. AMDA is professional association which represents over

7,000 physicians working in long-term care facilities either as medical directors or attending physicians.

I wish to applaud the Chairman and his colleagues for their willingness to take on the critical issue of long-term care at a time when most policymakers are reluctant to address any social concern which may potentially have a price tag attached. While Iran-Gate, Star Wars, and Disarmament are clearly issues of great concern and import, we as citizens of this country and you as policymakers of this Nation cannot afford to place long-term care in a holding pattern. The demographic imperative combined with the changing nature of the acute side of medicine has created a window of both opportunity and demand. Your proposed legislation is therefore timely and appropriate.

During the past 2 years, we have been witness to a series of actions all of which have focused upon the care being provided within America's nursing homes. These have included events as disparate as a film starring Kirk Douglas (less than and accurate description), a comprehensive 2 year study by the Institute of Medicine, a highly critical report by the Senate Special Committee on Aging (Heinz Report), and most recently hearings on the Senate Side chaired by Senator Mitchell. While there clearly remains work to be done in assuring that all patients regardless of illness, location, race or income receive the highest possible quality of care, it would be both unfair to the industry and damaging to public morale, if we were not to acknowledge how far we have come.

Some 15 years I ago I was the Director of the Maryland Governor's Commission on Nursing Homes for the State of Maryland. The Commission set up to investigate the State's long-term care system following the death of 36 patients from Salmonella, spent 2 years analyzing all aspects of the care system from facilities to State regulatory agencies. The problems we found were many and serious including: noncertified and ill-trained administrators; uninvolved and nongeriarically trained physicians; untrained and unappreciated nurse aides; biased and complacent surveyors; and, inadequate reimbursement. In short it was an industry in trouble.

Contrast those dark days with the present environment: Administrators who are licensed, certified and responsible for hours of continuing education; physicians who derive from family practice programs, are trained in geriatrics, and who have become key actors on the long-term care team; nurse aides who are required by many States or facilities to participate in a training program which includes a competency examination; surveyors who are far better trained and who have a survey instrument (PACS) which for the first time provides for direct patient assessment rather than paper compliance; and, a reimbursement system which is currently under review by policymakers knowledgeable as to the resources required to insure quality care.

It is my hope Mr. Chairman that any legislation which derives from this Congress is based on the premise that we have an industry which is engaged in delivering critical services to a dependent population and that by and large, it is doing a damn good job. Working from that base, allow me to comment on several of the provisions in your legislation of particular importance to my Association and Foundation.

1. *Nurse Aide Training*—I would begin by suggesting that we change the name from nurse aide to resident aide. While the aides are trained and supervised by nurses, there can be no denying that it is the facility resident for whom they render care. Second, I would urge the establishment of a national nurse aide training and certification program. Building upon the existing programs offered by several States and facilities, this national venture would seek to standardize the content, process and testing procedures across the Nation. Such a standardization would be beneficial to: patients who would move or be transferred; resident aides who would cross State lines for employment; and State and Federal surveys seeking a national assessment vehicle. My Foundation has devised such a national training and certification program (voluntary) and is currently seeking funding for its testing and implementation. (We will be working with the Education and Testing Service in Princeton, NJ).

2. *The Role of the Medical Director*—As I know you are aware, the patient/resident mix in today's long-tern care facility no longer reflects the picture of 10 years ago when most patients/residents were chronically ill, immobile and required little more than bed-side attention. Today you have nursing homes with ventilator-dependent children, AIDS patients, brain-damaged adults, sub-acute or super-skilled "DRG" patients, Alzheimers victims, and the traditionally chronically ill. Clearly there is a need for the medical director to be directly and continuously involve in all aspects of care from admission screening to on-going patient responsibility.

Indeed I would argue that it is more important and I suspect more realistic, to increase the participation and renumeration of Medical Directors than it is to require 24-hour registered nurse coverage, given the difficulty of many facilities, especially those outside of the large urban centers, to recruit trained nurses. The majority of residents in skilled and intermediate facilities, especially those who have been there for some length of time have lost contact with their personal physician and rely on the services of the medical director. (We do support however, the right of every resident to chose her/his own physician where possible.) If we are going to demand, and we should, that physician care within a facility be of the highest quality then we must have a reimbursement rate per visit that is significantly higher than $8 to $12 dollars. While money cannot and should not be the only motivator, a realistic rate of $16 to $20 will attract and retain the best and the brightest.

There are also two administrative/regulatory issues which if changed could facilitate the effective and efficient delivery of care. Many of the initial regulations concerning physicians were written to meet the lowest common denominator. While this was also true for other professionals and aspects of the facility, the new survey process has moved towards optimizing and away from leveling. We should now regulate the medical director and attending physician in a similar manner. For example:

A. *48-Hour Rule*—Medical Directors and attending physicians are now required to counter-sign over the phone orders within 48 hours of the call. The practically of this approach, given the mail service and the ongoing duties of the physician belie its compliance. Additionally however, this rule focuses the regulatory spotlight upon the wrong issue. We should be concerned that medical directors and attending physicians are aware of and ready to intervene in cases where patients are having an acute episode or when significant changes are taking place. A physician calling in a sleeping medication should not have to be responsible for 48-hour signature compliance. In short we should not work off the acute hospital model but rather "Pac" the physicians by focusing on patient care rather than paper compliance.

B. *30-Day Rule*—Here also the lowest common denominator was the basis for the origins of this rule. The State and Federal Government wanted to ensure that a physician was "present" at "least" every 30 days. Such a rule says little about the care provided, doesn't focus on critical events such as patient assessment, and doesn't take into consideration the patient mix in any one facility. I suggest that at a minimum we change the rule to read once a month or from 27 days to 35 days. Under the current system, a physician who schedules his visits for the first Saturday in every month would soon be out of the "30 Day" compliance in that there are months with more than 30 days. The optimal situation would be to use an experience based model wherein physicians would be granted waivers from the 30-day rule where they could show that the care provided was of the high quality and where the patient mix clearly did not call for 30 day visits.

C. *Certification and Training*—I would also urge, Mr. Chairman, that you require medical directors and attending physicians to receive 1) Continuing Education Hours on an annual basis, and 2) Be certified on a national basis including a competency examination on geriatric-related care. We require continuing education and/or certification for administrators, nurses, and aides (proposed). Is is not time we do the same for the individual responsible for the overall medical care within the facility? The American Medical Directors Association is in the process of developing both a Continuing Education requirement and a Certification process. We are working with the Educational Testing Service at Princeton and hope to have a program in place by this time next year. Federal legislation (could be administered by States) and or regulations on both the medical director and the nurse aide certification program would be of great value in moving this effort forward.

3. *Integration of ICF's and SNF's*—While I am in complete favor of eliminating the artificial levels of skilled and intermediate care, I believe the approach outlined in your proposed legislation, to require ICF's to meet SNF standards is impractical and delays what I see as the needed outcome. First, you proposal would cause great concern and problems for the small, rural ICF which is providing a badly needed community service but could not possibly meet SNF standards. Yes, they could apply for a waiver but I am not sure Mr. Chairman that you wish to open yet another pandora's box full of waivers. I suggest that you, in collaboration with your senatorial colleague, establish a Long Term Care Commission, the first task of which, would be to develop a case-mix/acuity-based reimbursement system, for implementation by 1990. While levels of care is an idea whose time has passed, residents, families, providers, facilities and regulators will be better served by phasing out the existing system and phasing in case mix reimbursement, rather than creating the nightmare of ICF/SNF integration.

Mr. Chairman, I appreciate your time and consideration and look forward to working with you and your staff in the weeks and months ahead. I would be pleased to answer any questions.

Mr. **Waxman**. Mr. Willging and Mr. Rodgers, both of you stated in your testimony that the issue of intermediate sanctions would best be addressed at the State level, and that there's no need for intervention at the Federal level.

I assume both of you were here when we heard the testimony earlier from the two women who described what their mothers either were going through or had gone through in a nursing home. They each testified that the States took virtually no action to rectify what I think both of you would agree were deplorable conditions. These are not isolated examples of poor quality care where the States take no corrective action. Newspapers all over the country have reported similar stories.

In light of this testimony and in light of the fact that States are hardly in the position to shut down facilities altogether, why do you think States are in a better position to address the issue of intermediate sanctions?

Mr. **Willging**. Well, in particular, with respect to the case in Tennessee, Mr. Chairman, I would argue again, based on data from the State of Tennessee, that the issue was not the fact that States do not have or do not use their sanctions. If the State of Tennessee can be faulted, which perhaps it can, it should be faulted perhaps for trying to take a bad facility and turn it into a good one before utilizing the sanctions available to it.

Indeed, the record shows that for a brief period, when the management of the facility was moved over to the Adventist group, the facility turned out to be a pretty good facility. Unfortunately, after 1 year's time, the greed and avarice of the owner took over, terminated the contract with the Adventists, and the facility began to drop down into the pits where it was prior to the Adventist group having managed it.

At that time, the State decided enough is enough. It utilized its authorities and, in fact, has begun decertification proceedings.

In the State of Tennessee, the State took 33 actions; 12 State-appointed monitors, 14 suspensions of all admissions, 4 restricted licenses, and 1 license revoked. My contention is, the State has the authority; the State is using the authority. The Federal Government's responsibility is to make sure the States use the authority they already have, rather than specifying new authorities.

Mr. **Waxman**. So you think there ought to be intermediate sanctions at the State level?

Mr. **Willging**. I think that what the State chooses to do, as long as it does it, should be a State decision. The Federal Government should be involved in monitoring, in policing, utilizing its look-behind authority and penalizing States that don't use whatever authorities they think are most appropriate.

Mr. **Waxman**. Mr. Rodgers, what do you think?

Mr. **Rodgers**. Yes. I would just simply add to my colleague's comments that we think that in certain cases the special rules provided in your legislation will serve to clarify some of these issues.

But again, I think that one needs to take a look at the tremendous variety and variability State by State and indicate—try to take some indication of whether or not the Federal Government is in a better position to do this than the individual State agencies to police and to enforce regulations.

It seems to me that there can be standards established in terms of Federal look behind surveys and other mechanisms to ensure that States comply with taking a look at enforcing sanctions, and if they don't, then that there be some administrative sanctions or penalties levied against the States.

Mr. **Waxman**. The legislation only requires that States have certain intermediate sanctions in place. It does not require that States ever use any of them. The bill does allow both levels of government to impose sanctions; however, the legislation specifies what sanctions shall prevail when both parties do, in fact, seek to impose sanctions.

Do you think that the Federal Government, which is spending such an incredible amount of money supporting nursing homes, shouldn't have a say in what should be done when a nursing home facility is not acting in compliance with the law? Shouldn't the Federal Government be able to impose some sanction short of closing them up completely?

Mr. **Rodgers**. I think that's a very difficult question. Obviously, the Federal Government certainly should have some say in that area, but I think that because of the discrepancies between States and the Federal Government that some system needs to be worked out.

As I said, I think that some of the special rules will help to clarify that issue in relationship to enforcement and some of the intermediate sanctions.

Mr. **Waxman**. What penalties would you recommend be imposed against facilities like the ones described by our first two witnesses—that is, against chronic and repeat offenders?

Mr. **Rodgers**. I think if you're talking about chronic and repeat offenders, that they should be closed down, terminated entirely, and I think that our association would stand for that, too.

Mr. **Willging**. Indeed, Mr. Chairman, I think and I would argue again——

Mr. **Waxman**. Why shouldn't there be an intermediate step in there? Why can't there be intermediate penalties?

Mr. **Willging**. There are intermediate penalties, Mr. Chairman. There are, as recently as last year, the new intermediate sanction regulations following enactment, admittedly belatedly, by this Congress 4 years ago, a ban on admissions. There are, within the existing authorities, in terms also of the fasttrack termination procedures, a total termination. But in terms of the simple, noncompliance with a condition of participation, a 90-day termination, which, in fact, can be overruled if the facility makes demonstrable progress toward improving the situation.

I am suggesting not that there shouldn't be intermediate sanctions, but that the sanctions are there. They need to be used.

Mr. **Waxman**. Mr. Wyden.

Mr. **Wyden**. Thank you, Mr. Chairman.

Dr. Willging, Mr. Rodgers, Dr. Baxter, I understand that all of you support the idea for periodic resident assessments and an understanding of their importance in an outcome system. I also understand that all of you have expressed some concern about the penalties that would be imposed on an individual who knowingly and willingly falsified a resident assessment.

I think everybody would say this is a tough standard. At the same time, I think we all feel the resident assessment has got to be the cornerstone of quality assurance. If you don't have a good resident assessment approach, you're not going to be able to do what we need done in quality assurance.

My question to you would be, if all of you think the present kind of penalty system is not the way to go, what alternative approaches might you have for the record, so that we could have some real substantive deterrent to those who engage in fraudulent activity?

Mr. Rodgers or Dr. Willging, if one of you wishes to start.

Mr. **Rodgers**. Well, let me just simply reiterate what I mentioned in my testimony, Mr. Wyden, and that is the system that is employed in New York State under the RUG system right now, where there was continuous, inaccurate assessment of, you know, patient data, that the State then puts in an independent evaluator, assessor, so to speak, and the facility is required then to pick up the cost of that assessment. I think that that's more of a positive incentive for ensuring that facilities complete accurate assessments.

In areas where they don't comply, you know, they run the risk of having somebody put in there to do the assessments and will have to pay for it out of their own pockets.

Mr. **Wyden**. Before we go to Dr. Willging on that point, Mr. Rodgers, has there been evidence in New York that that approach reduced problems with fraudulent assessments?

Mr. **Rodgers**. I would defer to my colleague from New York on that, Mr. Congressman.

Mr. **Baxter**. Congressman, if I may speak to that, since we've been operating under that system for some time, I think it's very difficult to have evidence to that at this point, and let me explain why.

When the assessment instrument which was mandated by New York State was put into place, there was massive training throughout the State of people to use that. Assessors who perform that assessment must go through that certified training program. They must have a certificate in that. No one else can fill out an assessment other than one of those individuals, and, in fact, if there are persistent problems with a particular individual, they will lose the ability to conduct assessments.

Let me explain why there's a problem, however, looking at the pattern. The State, in promulgating this instrument—and I suspect this will be the problem with any standard instrument promulgated—went through a process of changing the instructions for that instrument at least 25 times, changing the wording of different items within that instrument. People were unfamiliar with it.

So although throughout the State you had a period that I think has now shaken down, of people having a great deal of confusion about what to do, I could not tell you, based on that, what's been a pattern of confusion of poor wording of questions and that sort of thing as opposed to a question of actual falsification.

Mr. **Wyden**. Dr. Willging.

Mr. **Willging**. I would support the recommendation made by Mr. Rodgers, but for more reasons than those laid on the table. I think the issue of the importance of the resident assessment is absolutely critical. If anything, that was the focal point of the IOM study, focused on the patient, the patient's needs, the patient's care.

I think that we should therefore worry, Mr. Wyden, not just about those patient assessments willfully and wrongfully filled out, which is the way the legislative language reads, but even those sloppily filled out, not accurately filled out, carelessly filled out. And the suggestion made by Mr. Rodgers takes us away from simply a penalty again, dealing with those who would willfully abuse the system, and deals with the entire comprehensive approach that we're trying to deal with.

Mr. **Wyden**. Mr. Kerschner.

Mr. **Kerschner**. Yes. I would also like again, Mr. Wyden, reiterate the need for the doctor to play a role here. The physician gets off the hook. Rarely are there any sanctions placed by the State or the Federal Government on the physician in the facility. It's always the nurse or the administrator, the aide or whatever.

The physician, if you want him there or her in there and you want them to play a major role, then you have to have tight enforcement about his behavior, as well as the other people in the facility.

Mr. **Wyden**. I believe you use incentives wherever you can. At the same time, I think we have to understand that if people, even with incentives, deliberately go out and falsify, there has to be something there. I think this is going to need some continued discussion.

One last question, if I might. Dr. Baxter, on the question of the AIDS issue you are, expressing concern that the AIDS long-term care population could be vulnerable under this legislation. Do you have evidence of special problems such as the dumping of AIDS patients? What is the nature of the problem and what do you think we should do in this bill to deal with it?

Mr. **Baxter**. I would say at this point it's almost impossible to find evidence of persons with AIDS being dumped by a nursing home because the great majority of nursing homes are not caring for persons with AIDS in the first place. The place to look is at the back up of persons with AIDS in acute care hospitals, when they no longer need acute levels of care, they need long-term care or they need residential care or they need home health care and those providers have as yet been generally fearful or reluctant or concerned about the cost implications, for whatever reasons, and have not really stepped to the floor in terms of providing those services. Hopefully that will change.

Mr. **Wyden**. Thank you, Mr. Chairman.

Mr. **Waxman**. Mr. Walgren.

Mr. **Walgren**. Thank you, Mr. Chairman.

How does the thought of a case mix payment system dove tail with the need for some kind of floor where a facility would be able to handle or people would be assured that a facility would be able to handle what I gather must be presented in almost all nursing home situations, if you have a case mix situation, and you have one case that requires let's say a registered nurse in the mix, but you just have one case of that kind, wouldn't you then need a registered nurse available at all times?

If that's the case, doesn't it make sense to look at this as requiring some kind of floor of basic care that people would be assured of?

Mr. Willging. There is no question that floors need be developed, Mr. Walgren. The issue I think is not whether you need floors. The issue is do you develop a floor for an entire industry, for an entire array of facilities or do you relate that floor to each facility. Indeed, I would argue that in many intermediate care facilities, which are not in many States currently required to provide 24-hour nursing, the care is still excellent. The reason is that the patients in that particular facility, other than during the day shift, do not need an on board 24-hour nurse.

What the acutely based assessment and reimbursement system does is relate the staffing needs and ultimately then the reimbursement to the individual needs of that facility based on the needs of the patient. I would agree with you, if that facility has just one patient which requires 24 hour nursing, then that is the floor for that facility but based on the needs of the facility which in turn is based on the needs of the individuals within the facility.

Mr. Walgren. You mentioned in your testimony that you were concerned that increased costs for staff would not be able to be recovered from the rest of the system. You said that the Federal contribution is only 23 percent and therefore, if the Federal requirement was of an increased staffing level, that we would only be paying 23 percent of that. We are paying approximately 50 percent of the Medicaid burden; are we not? The Federal Government would be paying 50 percent at least?

Mr. Willging. No, let me explain my reason. I spent a number of years in HCFA, Mr. Walgren, trying to deal with this crazy program called Medicaid. I learned it almost as well as the Chairman perhaps knows the Medicaid program. It is an entitlement program based on what it is the States spend. The Federal share comes into play only if the States spend dollars which are to be matched.

Let me give you a simple example. The State of Oklahoma; the State of Oklahoma has almost no SNF's whatsoever. It is almost all ICF's. Let me suggest that it is time that we deal with this crazy distinction, SNF/ICF. Conceptually, it makes no sense. The issue is how do we pay for the change.

If this legislation were to pass and the State of Oklahoma, experiencing severe financial difficulties today, were to in effect have to take all of its SNF's and move them up to the standards—all of its ICF's and move them up to the standards pertaining to a SNF, there is a $10 differential in almost every State between the care provided in an ICF and the care provided in a SNF.

I'm willing to bet you dollars to doughnuts, Mr. Walgren, that the State of Oklahoma will not reflect in its reimbursement rates those increased costs to the ICF's that suddenly by waving the magic wand become SNF's. Therefore, the Federal Government will incur no additional cost because unless the State asks for it, the Federal Government does not come into play. That is our concern that by changing these standards without provisions for the costs being reflected in the rates at the State level, we will take a promise of increased care to the American public and turn it into a false promise, because that care will not only increase, it will decrease as facilities grasp for mechanisms to come into compliance with this new standard probably by going out of compliance with some other standard.

Mr. **Walgren**. If the Federal Government starts to ask for greater requirements in the Medicaid program, somehow or another we have to change the relationship of the Federal Government with the States. Certainly we have very real requirements now for Medicaid participation by the States.

Would not some similar requirement cover that problem?

Mr. **Willging**. I'd refer to previous testimony today, Mr. Walgren, and I will relate here the second story, that is from the State of Illinois. Mr. Vladeck, I believe, suggested correctly that for a number of years, at least 7 years, the Federal Government has not bothered to enforce existing legislation that reimbursement be reasonably related to the care provided.

The question was asked, what was the rate to this facility in the State of Illinois when the problems were taking place. The answer is the rate was $24 per day. $24 per day in a skilled nursing facility designed to cover room, board, activities, therapies, the entire gambit of services that we require of States and of facilities.

If we do not deal with this issue of reimbursement, we are going to be in serious difficulty.

I would agree with Mr. Vladeck. Reimbursement is not a sufficient criterion for high quality care. It is certainly a necessary criterion for high quality care.

Mr. **Walgren**. Thank you, Mr. Chairman.

Mr. **Waxman**. Thank you, Mr. Walgren.

Mr. Bruce.

Mr. **Bruce**. No questions, Mr. Chairman.

Mr. **Waxman**. Gentlemen, thank you very much for your testimony. We will look forward to working with you on this legislation.

We are pleased now to call forward and recognize Congressman Claude Pepper who is the original sponsor of H.R. 2270 and was instrumental in bringing about the Institute of Medicine study on which the bill is based. I don't think any Member of Congress has been more persistent and vigorous in pushing for better long-term care services for the elderly. It is a privilege to have you with us. We look forward to your comments on this bill and working with you toward its enactment.

## STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. **Pepper**. Mr. Chairman, I thank you very much for the privilege of being with you and your subcommittee today. I ask unanimous consent that my statement be inserted in the record.

Mr. **Waxman**. Without objection.

Mr. **Pepper**. I will summarize it.

Mr. Chairman, I'm very grateful for the privilege of having been on legislation with you and your distinguished Chairman, Mr. Dingell, in trying to find a way to improve conditions for the people in the nursing homes of this country.

There are some 1.5 million people confined in these homes. I understand the Government pays about 55 percent of the cost of their being there because the pay comes primarily from Medicaid and I understand the Government pays about 55 percent of the cost of Medicaid.

I have just learned from a member of my staff that possibly the Government is not paying but about $1,200 a month for nursing home care. I think he told me the Government paid about $40 a day. That would be about $1,200 a month. I wonder if that is really enough to require the best kind of treatment for these people in nursing homes.

These people are generally more or less dependent and to a large degree helpless people. Their average age is about 83. About 9 out of 10 have no relatives or they are alone. About half of them have Alzheimer's disease and the other half have arthritis or heart disease or hypertension, something like that. These are relatively helpless people that are confined in these homes.

We have tried for years and I remember years ago holding hearings from the Aging Committee. I remember one hearing we had in Rhode Island. We were working on the same problem that we are still working on now, trying to get better inspections and greater and more complete care for these people. I've come to the conclusion that we can no longer rely on the States to make these inspections in nursing homes.

The Federal Government, since we put up most of the money that makes it possible for the patients to be there, the Federal Government ought to take full responsibility by its own inspections for the quality of care given to these people that are there primarily by Federal money.

Too often I have found out that the State inspectors behave somewhat like some of the sheriffs back in the prohibition days. They let the distiller know they were coming before they visited the still. Too often I think these State inspectors let the nursing home proprietors know when they are coming. There is very little ever done about it.

I suggested to the farmer Governor of Florida one time, and his lovely wife is very much interested in the elderly, I suggested to her that we use to a large degree elderly people as inspectors for the State. She transferred me to her husband, the Governor, and he said, yes, that sounds like a good idea, and then he said, wait a minute, I have to consult my Agency that handles this sort of thing, and nothing ever came out of it. We have the same kind of inspections we had been having.

If we had the elderly people as inspectors, they would be more sensitive to the needs of the elderly there. They would be more considerate and passionate.

Mr. Chairman, I think the time has come for us to lay down a code, describe a bill of rights that these people are entitled to have as their protection in a nursing home, posted everywhere so everybody can see it, and with some assurance that bill of rights will be protected. They would be granted what the bill of rights calls for.

I would consider looking into it, Mr. Chairman and members, as to whether we are paying enough to get the quality of care they should have. If we are not paying enough, we should pay more so they will be justified in getting quality care.

Every nursing home should have a trained nurse on duty all the time. These elderly people need protection.

In my statement, I pointed out one case where two nurse aides held a 90 year old woman, I guess she wasn't eating and they were trying, and maybe in good faith, to give her nourishment. Two of them held her while another one poured several ounces of food or liquid down her throat and she died. A trained nurse probably wouldn't have treated that elderly lady that way or permitted that kind of treatment to her by the aides in the nursing home.

First, let's see if we are paying enough. Second, let's lay down a code of protection for these people in these nursing homes. Third, let's put full scale Federal inspection into effect. They are basically our people. We are basically paying for them being there. We ought to see that they are properly protected. I just don't think our experience justifies our relying upon the States to give good and adequate protection to these people.

I think it is just a part of the reform that we are striving to achieve. I commend your committee for what it is doing and will support your efforts in every way I can.

Thank you very much. Mr. Chairman.

[The prepared statement of Mr. Pepper follows:]

## STATEMENT OF HON. CLAUDE PEPPER

Chairman Waxman, Members of the Subcommittee, I deeply appreciate the opportunity to be with you today to discuss the crucial matter of protecting those among the most vulnerable in our society—the 1.5 million Americans who reside in nursing homes. You and your committee are to be commended for taking a leading role in this most important area.

Over 5 years ago, the Reagan administration proposed to significantly weaken the Federal Government's role in regulating nursing homes. This proposal met with loud and widespread opposition from those who were concerned about the well-being of nursing home residents. My distinguished colleagues, Chairman Waxman and Chairman John Dingell, joined me in leading congressional opposition to the President's deregulatory plan and were successful in mandating a moratorium on all changes to nursing home regulations pending an independent national study by the National Academy of Science's Institute of Medicine.

After several years of study, the prestigious institute of medicine panel issued a comprehensive and far-reaching report. They confirmed the need for a strong Federal role in protecting nursing home residents. The panel's recommendation have given the Congress a blueprint for action. Failure to take swift and bold action, in light of the following facts, would be unconscionable

- NURSING HOME RESIDENT ARE OLD. Their average age is 83.
- THEY ARE ALONE. Nine of 10 have no living spouse.
- THEY ARE VERY ILL. Half have Alzheimer's Disease. Half have heart disease, hypertension, and/or arthritis, one of three have impaired vision or hearing. Most have multiple chronic conditions.
- THEY ARE VERY DEPENDENT. Nine of 10 require assistance in bathing. Four of 10 require help in eating.
- THEY STAY FOR A LONG TIME. Only one in five will ever return home.

A recent survey by the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging confirmed the shocking conditions many frail elderly nursing home residents face. Highlights of our findings included:

- Over 200,000, or 15 percent of nursing home residents, may be the victims of physical or sexual abuse or neglect each year.
- Over 300,000, or 20 percent, may be denied a safe and clean living environment, some are exposed to pitiful squalor.
- Over 500,000 or 35 percent, may be denied adequate or appropriate medical and nursing care. The average resident of a skilled nursing home receives less than 2 hours of direct care daily—1 hour and 15 minutes from mostly untrained nurse aides, 27 minutes from licensed or registered nurses, and 30 seconds from medical doctors!

- Some 700,000, or 45 percent, may be denied the right to maintain personal possessions. Many are the victims of frequent thefts.
- Over 800,000, or 75 percent of nursing home residents, may be denied basic right to complain and seek redress of their grievances.

These appalling conditions take very personal and graphic forms:

- A 93-year-old resident of a Michigan nursing home was killed as the result of being forcefully restrained by two nurse aides while another aide forced the resident's mouth open and poured down three 5-once cups of liquid.
- An Arkansas resident was struck and forced to rub her own fecal matter on herself and eat her own feces.
- An elderly Washington, D.C. woman was placed by a nurse aide in a tub of scalding bath water. Instead of calling a doctor, they wrapped her in sheets to hide the wounds. She died several days later.

These disgraceful incidents are allowed to persist due to weak nursing home standards and even weaker Federal and State enforcement. Federal Standards:

- Do not require 24-hour registered nursing care, allowing untrained nurse aides alone to care for residents during the night.
- Do not protect residents from discrimination based on their source of pay, leaving thousands vulnerable after having exhausted all of their financial resources.
- Do not measure quality of care or life. Only 1 percent of these standards measure the actual provision of quality care.
- Allow nursing home cited continuously for violations for poor care to go unpunished due to repeated "pardons" are legal appeals.

Although officials at the U.S. Department of Health and Human Services claim to be taking an aggressive stance against substandard nursing homes. The facts seem to indicate otherwise:

- The Federal government has reduced the number of nursing homes it inspects from 278 in 1985 to 148 in 1986, nearly a 50 percent cut. There are 15,000 nursing homes in the Nation.
- Of the 148 "look behind" inspections performed by the Federal Government in 1986 (most of which targeted nursing homes with violations documented by State inspectors), only 9 resulted in the initiation of adverse actions.
- The number of nursing homes closed by the Government due to violations is still shockingly small. In 1986, only 74 of the Nation's 15,000 nursing homes lost their Medicare and Medicaid certification. Most of those are now back in business.
- Most States rarely employ alternative penalties against nursing homes.

I am very pleased to have joined Chairmen Dingell and Waxman in sponsoring legislation which builds upon the recommendations of the landmark institute of medicine study and report and goes a long way towards assuring nursing home residents the protection they desperately need. It greatly improves many areas of nursing home regulation.

I feel strongly that we must take even further steps in certain critical areas to fully address the needs of nursing home residents. Most of these steps are outlined in H.R. 395, the nursing home resident protection act of 1987, I introduced in January:

- Nursing homes residents should be afforded at least the services of one registered nurse, 24 hours a day.
- We must not allow any form of discrimination against nursing home residents just because they have to rely on government assistance to help pay for their care.
- Inspections must be conducted on a random basis.
- There must be immediate penalties for facilities with repeat violations of patient care standards.

I look forward to working with this distinguished committee as the legislative process continues to ensure that meaningful and lasting nursing home reform becomes law. We have waited a long time. Our Nation's 1.5 million nursing home residents have waited long enough.

Thank you for your attention and continued excellent work on behalf of those need.

Mr. **Waxman**. Thank you very much, Mr. Pepper, for your testimony and your leadership. We certainly do look forward to working with you.

Let me just ask if Mr. Walgren or Mr. Bruce have any questions.

Mr. **Walgren**. Mr. Chairman, if I might, and I realize we are late on time, but all of us always underscore the degree of inspiration you are to us and want to express my appreciation for that but to think also of the circumstances that a family is in when putting somebody in a nursing home. They want to rely on something or somebody. We want it to work out right. We almost make it up. Since the Federal Government has some standards in this area, it would seem to be the instinct of people to say, well, the Federal Government has approved this, therefore it must be all right.

What you are saying is we haven't met our responsibility to the other side of that equation.

Mr. **Pepper**. The Federal Government is reducing, my friend, the number of inspections instead of increasing them. That's not right.

Mr. **Walgren**. Thank you very much, Mr. Chairman, and Mr. Pepper.

Mr. **Waxman**. Thank you, Mr. Pepper.

We have a vote on the House Floor.

We're going to take a short recess to respond to the vote and then come back and hear from our next panel; after that we'll break for lunch.

[Brief recess.]

Mr. **Waxman**. The subcommittee will come back to order.

Our next panel is composed of witnesses representing the workers in nursing homes who provide the actual services to residents. Mr. John J. Sweeney is president of SEIU, the Services Employees International Union; Dr. Charlene Harrington is associate director of the Institute for Health and Aging at the University of California at San Francisco. Dr. Harrington also served as a member of the Institute of Medicine Nursing Home Study. She is testifying today on behalf of the American Nurses Association. The last witness on this panel, Ms. Helen Isferding, is a staff representative with Wisconsin Council 40 of the American Federation of State, County and Municipal Employees.

I thank each of you for joining us today. Your prepared statements, of course, are already part of the record, and we would like to ask you to summarize them for no more than 5 minutes.

Mr. Sweeney, why don't we start with you.

## STATEMENTS OF JOHN J. SWEENEY, INTERNATIONAL PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO; CHARLENE HARRINGTON, ON BEHALF OF AMERICAN NURSES' ASSOCIATION; AND HELEN ISFERDING, ON BEHALF OF AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

Mr. **Sweeney**. I'm John Sweeney the president of the Service Employees International Union, AFL-CIO. On behalf of our 850,000 members, Mr. Chairman, I thank you for the opportunity to testify today on the current legislative efforts to promote quality care in nursing homes. With me is a member of our staff, our economist Peggy Connerton.

I'm especially grateful for the opportunity of speaking on behalf of the 100,000 of our members who work in nursing homes. Most of these members are nurses aides, dedicated men and women working at extremely low wages, who provide the bulk of direct patient care in nursing homes. But equally important, they often are the only advocates for and the defenders of elderly people who have been all but abandoned by our society.

Nursing homes you see are not facilities like hospitals where patients receive treatment designed to improve their health. Nursing homes are institutions where we put people when we have run out of ideas, money or patience. Very often the occupants of nursing homes are people who have been institutionalized by default or actually dumped by their loved ones and their families.

It is in this kind of environment that nursing home workers daily make the difference between comfort and dignity or agony, depression and death. It is therefore one of the great ironies that nobody really listens to nursing home workers. We listen to doctors. We listen to industry representatives. We listen to policymakers. But rarely do we listen to those who really care for our Nation's elderly.

Today is one of the rare occasions when nursing home workers get a chance to be heard, and we are indeed grateful. The 100,000 nursing home workers who are members of Service Employees wholeheartedly support H.R. 2270; and on their behalf I want to comment on four provisions of the bill.

Perhaps most important are the provisions requiring tougher inspections. Reinspection of facilities that change ownership and intermediate enforcement measures.

Our members know that present inspection systems are a joke. They know inspections are coming when they see supply and linen closets mysteriously filling up, extra staff being added, neglected cleaning being done.

And they have seen what happens when large corporate chains take over homes and make swift changes in staffing levels, supplies and patient care.

Unannounced inspections and reinspections after takeover would be a significant step toward adequate protection against the greed and carelessness of some nursing home owners.

Equally important, the intermediate enforcement solutions proposed by H.R. 2270 will allow punishments that check up short of decertification. The only Federal solution now available, and one which isn't used very often because it puts residents and workers on the street at a time when there is a critical bed shortage.

We also strongly favor the provisions of H.R. 2270 which restrict the ability of nursing home operators to discriminate between Medicaid patients and private paid patients. Discrimination occurs in all areas in nursing home. Our kitchen helpers are told to prepare gourmet meals for some patients, budget meals for others. Our nurses aides are told to answer the call lights of private pay residents before those of Medicaid patients. What has developed is a two-tier system of patient care; one for the haves and one for the have-nots. And the bill is a great step toward restoring equity.

We're also delighted that H.R. 2270 bans several of the worse forms of admission discriminations against Medicaid patients. Coerce gifts and donations to nursing homes and certain kinds of contracts.

We would like to see even stronger signals to the industry. The nursing home industry claims that any antidiscrimination provisions would drive them into bankruptcy.

In our written testimony we demonstrate that operating margins in the industry are quite healthy, and we ask that you resist the call of those who would deny equal care on the basis of feigned financial distress.

We also applaud and support the portions of the bill which call for nurse aide training for those who work in nursing homes. But we suggest additional provisions strengthening employer accountability for the quality of training.

Further, we ask that you add a measure to help correct a problem which will negate any efforts to approve quality of care through training. That problem is chronic short staffing which is not addressed.

Finally, I submit to you the conditions in our nursing homes will not improve substantially without more and better trained staff; and we are simply not going to be able to attract, train, and keep the kind of people we need until the nursing home industry begins putting patient care on an equal footing with profits by paying decent wages and providing decent benefits to its workers.

Thank you.

[Testimony resumes on p. 367.]

[The prepared statement of Mr. Sweeney follows:]

# TESTIMONY OF
# SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC
# ON
# H.R. 2270
# THE MEDICAID NURSING HOME QUALITY OF CARE AMENDMENTS OF 1987

I AM JOHN J. SWEENEY, INTERNATIONAL PRESIDENT OF THE SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU). ON BEHALF OF OUR 850,000 MEMBERS, I THANK YOU, MR. CHAIRMAN, FOR THE OPPORTUNITY TO TESTIFY TODAY ON THE CURRENT LEGISLATIVE EFFORTS TO PROMOTE QUALITY CARE IN NURSING HOMES.

SEIU IS THE LARGEST HEALTHCARE UNION IN THE UNITED STATES, REPRESENTING 275,000 HOSPITAL AND NURSING HOME WORKERS. OUR 100,000 NURSING HOME MEMBERS KNOW FIRST-HAND THE OBSTACLES TO QUALITY PATIENT CARE IN THESE HOMES. THEY WORK DAY-TO-DAY WITH ELDERLY RESIDENTS UNDER CONDITIONS OF EXTREME HARDSHIP. NURSE AIDES WHO PROVIDE THE BULK OF DIRECT PATIENT CARE ARE ON THE FRONT LINES EVERYDAY. THEY WITNESS THE DEGRADING CONDITIONS IN WHICH THE ELDERLY IN THIS COUNTRY ARE FORCED TO LIVE OUT THEIR FINAL YEARS.

THEY TELL US ABOUT THE CHRONIC SHORT-STAFFING THAT LIMITS THE COMPASSIONATE CARE THAT THEY CAN DELIVER. THEY TELL US ABOUT THE CONSTANT EFFORTS OF ADMINISTRATORS TO TRIM THE MEALS AND BED LINEN BUDGETS.

THEY TALK ABOUT THE LACK OF TRAINING, THE HIGH TURNOVER, THE POOR SUPERVISION, THE POVERTY WAGES AND OTHER DEPRESSING WORKING CONDITIONS. THEY ARE DISGUSTED ABOUT THE "NO FRILLS" SERVICES THAT THEY ARE FORCED TO GIVE MEDICAID RECIPIENTS.

AND THEY LIVE THROUGH CORPORATE TAKEOVERS AND THE RESULTING CUTBACKS MADE BY MULTI-MILLION DOLLAR CORPORATIONS IN STAFF, SUPPLIES AND OTHER PATIENT CARE IN ORDER TO EXPAND PROFIT MARGINS.

FOR THESE REASONS, OUR WORKERS WHOLEHEARTEDLY SUPPORT H.R. 2270, WHICH IMPLEMENTS MANY OF THE NURSING HOME REFORM RECOMMENDATIONS OF THE INSTITUTE OF MEDICINE (IOM) AND THE CAMPAIGN FOR QUALITY CARE IN NURSING HOMES, IN WHICH SEIU PARTICIPATED.

THE BILL'S EFFORTS TO PROVIDE ASSESSMENTS OF ALL RESIDENTS, TO STRENGTHEN INSPECTIONS OF THE INDUSTRY, TO PROTECT RESIDENTS' RIGHTS AND TO PROVIDE MORE EQUAL ACCESS AND EQUAL SERVICES TO THE POOR WILL GO A LONG WAY TO UPGRADING THE STANDARDS OF CARE GIVEN OUR NATION'S ELDERLY IN NURSING HOMES.

THE REMAINING TESTIMONY WILL FOCUS ON THOSE PROVISIONS IN H.R. 2270, OF MOST INTEREST TO OUR WORKERS.

**ENFORCEMENT**

WE ARE PLEASED, MR. CHAIRMAN, THAT YOUR BILL GIVES STRONG PRIORITY TO ENFORCEMENT, OFFERING STATES A WIDE ARRAY OF INTERMEDIATE SANCTIONS TO USE IN DEALING WITH OWNERS WHO VIOLATE BASIC STANDARDS OF CARE. NATURALLY, STATES ARE RELUCTANT TO USE THE ONLY CURRENT FEDERAL PENALTY -- DECERTIFICATION -- BECAUSE IT PUTS RESIDENTS AND WORKERS ON THE STREET AT A TIME WHEN THERE IS A CRITICAL BED SHORTAGE. AS A RESULT, NEARLY 15% OF NURSING HOMES ARE CHRONICALLY SUBSTANDARD.

WE ARE ALSO PLEASED WITH THE CLOSER AND MORE FREQUENT MONITORING OF THE INDUSTRY BY THE OMBUDSMAN, AND GREATER PUBLIC ACCESS TO OWNERSHIP, INSPECTION, AND COST REPORTS IN THE BILL.

WE ALSO SUPPORT THE REDIRECTION OF INSPECTIONS -- AWAY FROM PAPER COMPLIANCE TOWARD AN ASSESSMENT OF PATIENT CARE. THIS WILL GREATLY INCREASE THE PROBABILITY THAT INSTANCES OF DRUG OVERDOSES, DIETARY DEFICIENCIES AND OTHER EVIDENCE OF PATIENT ABUSE WILL BE DETECTED.

PERHAPS MOST IMPORTANT ARE THE BILL'S PROVISIONS REQUIRING: (1) THAT INSPECTIONS BE UNANNOUNCED AND (2) REINSPECTIONS OF FACILITIES THAT CHANGE OWNERSHIP WITHIN TWO MONTHS.

CURRENTLY, MANY STATES SCHEDULE VISITS DURING THE SAME WEEK EACH YEAR. OUR NURSING HOME WORKERS ACROSS THE COUNTRY TELL US THAT THEY ALWAYS KNOW WHEN AN INSPECTION IS IMMINENT. THE SIGNS INCLUDE ORDERS TO FILL UP EMPTY SUPPLY AND LINEN CLOSETS, CAREFUL ATTENTION TO CLEANING, AND STAFFING-UP.

INTRODUCING THE ELEMENT OF SURPRISE AND VARYING THE SCHEDULED INSPECTIONS FROM 9 TO 15 MONTHS WILL GREATLY INCREASE THE CHANCE THAT REGULAR PERFORMANCE DEFICIENCIES THAT RESULT IN POOR-QUALITY CARE ARE IDENTIFIED AND CORRECTED.

SOME STATES NOW RECOGNIZE THE POWER OF UNANNOUNCED INSPECTIONS. IN WISCONSIN -- WHERE NURSING HOME COMPLAINTS INCREASED 72% IN THE LAST 2 YEARS -- THE STATE IS CONSIDERING USING A "SWAT TEAM" TO STEP UP SURPRISE INSPECTIONS OF NURSING HOMES.

OWNERSHIP CHANGES ALSO SHARPLY AFFECT THE QUALITY OF PATIENT CARE. STUDIES HAVE SHOWN THAT TAKEOVERS BY LARGE CORPORATE CHAINS FREQUENTLY RESULT IN SWIFT CUTBACKS IN STAFFING LEVELS, SUPPLIES AND OTHER PATIENT CARE COST COMPONENTS.

FOR EXAMPLE, COLUMBIA CORPORATION, A NEW FOR-PROFIT CHAIN WITH 40 HOMES AND 2,500 BEDS, PURCHASED TWO HOMES IN MASSACHUSETTS WHERE SOME OF OUR MEMBERS WORK. THEY IMMEDIATELY CUT BACK SHARPLY ON NURSE AIDES AND SUPPLIES. AS A RESULT, THE HOMES -- WHICH THE STATE HAD PREVIOUSLY LABELLED AS QUALITY CARE PROVIDERS -- WERE CITED FOR

SERIOUS PATIENT CARE VIOLATIONS (BEDSORES, AND LACK OF WRITTEN PATIENT CARE PROGRAMS). IN FACT, CONDITIONS WERE SO BAD THAT THE STATE EVENTUALLY DENIED COLUMBIA CORPORATION A LICENSE.

THE STORY IS THE SAME AT BEVERLY ENTERPRISES, THE NATION'S LARGEST NURSING HOME OPERATOR, WITH 121,800 BEDS AND A 12% MARKET SHARE. NUMEROUS STUDIES SHOW STAFFING CUTS OFTEN FOLLOW THEIR TAKEOVERS OF NURSING HOMES.

A RECENT SURVEY OF BEVERLY ENTERPRISES IN MICHIGAN FOUND THAT THEIR HOMES WERE CONSISTENTLY AMONG THE WORST-STAFFED HOMES IN THE STATE.[1] YET, THEY CONTINUE TO CUT STAFFING LEVELS --BY AN ESTIMATED 4.6% IN 1985 AND 4.8% IN 1986.

AS A RESULT, BEVERLY FACILITIES ARE OFTEN IN VIOLATION OF STATE NURSING HOME REGULATIONS. IN FACT, OVER 57% OF BEVERLY HOMES IN MICHIGAN WERE CITED FOR SHORT-STAFFING IN 1986, AS OPPOSED TO ONLY 20% OF NURSING HOMES IN GENERAL.

INSPECTIONS OF HOMES UNDER NEW OWNERS OR NEW MANAGEMENT WILL HELP IDENTIFY THESE TRENDS BEFORE TOO MUCH DAMAGE TO PATIENT HEALTH AND SAFETY OCCURS. IN GENERAL, ECONOMIC CONSOLIDATION OF THE INDUSTRY

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[1] SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 79, "BEVERLY ENTERPRISES IN MICHIGAN, THE STAFFING CRISIS IN MICHIGAN'S LARGEST NURSING HOME OPERATOR", APRIL 22, 1987.

HAS BROUGHT A HOST OF PROBLEMS. STATES NEED TO REVIEW CORPORATE OPERATIONS NATION-WIDE SO THAT THEY CAN PREVENT THE ENTRY OF COMPANIES WITH BAD PATIENT CARE RECORDS IN THE FIRST PLACE.

**MEDICAID DISCRIMINATION**

MEDICAID DISCRIMINATION IN THE NURSING HOME INDUSTRY IS RAMPANT. DISCRIMINATORY PRACTICES RANGE FROM SEPARATE WAITING LISTS FOR MEDICAID AND PRIVATE PAY PATIENTS TO UNEQUAL SERVICES WITH MEDICAID RECIPIENTS GETTING "NO FRILLS" SERVICES.

THESE DISCRIMINATORY PRACTICES ARE FAST TURNING NURSING CARE INTO A TWO-TIERED SYSTEM -- ONE FOR THE "HAVES" AND ONE FOR THE "HAVE-NOTS".

THE CHRONIC BED SHORTAGE IN THIS INDUSTRY ALLOWS NURSING HOME OPERATORS TO DISCRIMINATE ON BOTH PRICING AND QUALITY. STATES ARE RESTRICTING BED GROWTH TO HOLD DOWN MEDICAID COSTS AND THE BIG CORPORATE TAKEOVERS WASTE CAPITAL THAT COULD OTHERWISE GO TO MORE BEDS. THESE PATTERNS MEAN THAT MEDICAID DISCRIMINATION CAN ONLY GET WORSE; THE PROBLEM WON'T GO AWAY.

FORTUNATELY, H.R. 2270 TAKES A GIANT STEP FORWARD IN RESTRICTING DISCRIMINATION IN BOTH COVERED SERVICES AND ADMISSIONS PRACTICES. WITH RESPECT TO SERVICES, H.R. 2270 REQUIRES EQUAL TREATMENT IN ALL MEDICAID-COVERED SERVICES. OTHERS HAVE TALKED THIS MORNING ABOUT THE EFFECT DISCRIMINATORY PRACTICES HAVE ON RESIDENTS. I WANT TO

TELL YOU OF THEIR IMPACT ON WORKERS WHO ARE TOLD TO DISCRIMINATE -- TO DELIVER DIFFERENT LEVELS OF NURSING CARE TO PATIENTS BASED ON THEIR SOURCE OF PAYMENT.

DISCRIMINATION OCCURS IN ALL AREAS IN NURSING HOMES. OUR KITCHEN HELPERS ARE TOLD TO PREPARE GOURMET AND BUDGET MEALS. OUR NURSE AIDES ARE TOLD TO ANSWER THE CALL LIGHTS OF PRIVATE PAY RESIDENTS BEFORE THOSE OF MEDICAID PATIENTS. THEY ALSO ARE TOLD TO GIVE MORE "CUSTOMIZED" SERVICES TO PRIVATE PAY PATIENTS AND ONLY BASIC CARE TO MEDICAID PATIENTS. AT ONE HOME, STAFF WERE ASSIGNED TO WORK AT A SPECIAL BINGO NIGHT FOR WELL-TO-DO PATIENTS, WHILE MEDICAID PATIENTS WAITED TO BE BATHED AND FED.

A BAN ON UNEQUAL SERVICES IS NOT ENOUGH . SUCH A BAN WILL INCREASE NURSING HOME OPERATORS' INCENTIVES TO SHUT OUT PUBLICLY-FUNDED PATIENTS.

EQUAL SERVICES AND EQUAL ACCESS FOR THE POOR MUST GO HAND-IN-HAND. OTHERWISE, WE RISK INCREASING DISCRIMINATION AGAINST THE MEDICAID DEPENDENT ELDERLY.

H.R. 2270 ELIMINATES SEVERAL OF THE WORST FORMS OF MEDICAID DISCRIMINATION IN ADMISSIONS PRACTICED BY THE INDUSTRY. IT PROHIBITS THE SHAKEDOWNS FOR GIFTS AND CONTRIBUTIONS AS A CONDITION FOR

ADMITTING A MEDICAID RESIDENT. ALSO, IT ENDS PRIVATE-PAY CONTRACTS WHICH REQUIRE RESIDENTS TO WAIVE THEIR RIGHT TO MEDICAID BENEFITS FOR A SPECIFIED PERIOD OF TIME.

THE NURSING HOME INDUSTRY CLAIMS THAT ANY ANTI-DISCRIMINATION PROVISIONS WOULD DRIVE THEM INTO BANKRUPTCY. THEY SAY THEY MUST ATTRACT MORE PRIVATE PAY PATIENTS TO SUBSIDIZE THE UNPROFITABLE MEDICAID PATIENTS. NURSING HOMES OFTEN POINT TO THEIR RAZOR THIN PROFIT MARGINS AS EVIDENCE THAT EVEN A FEW MORE MEDICAID RESIDENTS WILL JEOPARDIZE THEIR SOLVENCY.

NONSENSE. WE CAN'T DENY THAT PRIVATE PAYERS ARE MORE PROFITABLE, ON AVERAGE. HOWEVER, IT IS IMPORTANT TO NOTE THAT STATES SUCH AS NEW YORK, MICHIGAN AND MINNESOTA PAY HIGH MEDICAID RATES.

MOREOVER, NURSING HOMES' AFTER-TAX PROFIT MARGINS ARE ARTIFICIALLY DEPRESSED BY HEAVY DEPRECIATION CHARGES AND LEVERAGED BUY-OUTS. BY CONTRAST, THEIR OPERATING MARGINS (PATIENT REVENUES MINUS PATIENT EXPENSES) ARE THE MAIN BAROMETERS OF WHETHER THERE IS SUFFICIENT CASH FLOW TO COVER EXPENSES. AS THE ATTACHED TABLE SHOWS, OPERATING MARGINS ARE QUITE HEALTHY IN THE INDUSTRY, AT LEAST FOR THE TOP INVESTOR-OWNED CHAINS.

IN FACT, INVESTOR-OWNED CHAINS HAVE A HIGHER PERCENTAGE OF MEDICAID RESIDENTS THAN NON-PROFIT NURSING HOME CHAINS SHOWING THAT

MEDICAID CENSUS IS NOT AN OBSTACLE TO PROFITABILITY.[2] MOREOVER, THIS CHART SHOWS THAT THERE IS ONLY A WEAK CORRELATION BETWEEN PROFIT MARGINS AND PERCENT MEDICAID REVENUES.

AN SEIU ANALYSIS OF A SAMPLE OF 19 HILLHAVEN HOMES FOUND THAT PROFITABILITY FOR INDIVIDUAL HOMES ALSO HAS LITTLE RELATIONSHIP TO THEIR MEDICAID CENSUS. IN SHORT, ADDING MORE MEDICAID PATIENTS DOESN'T GENERALLY MEAN THE DIFFERENCE BETWEEN PROFITS AND LOSSES.

THIS BILL WILL PROHIBIT THE WORST TYPES OF DISCRIMINATORY ADMISSIONS PRACTICES, BUT IT WILL NOT END DISCRIMINATION AGAINST MEDICAID APPLICANTS. WE RECOMMEND SENDING EVEN STRONGER SIGNALS TO THE INDUSTRY THAT DISCRIMINATORY ADMISSIONS PRACTICES MUST STOP.

THE SERVICE EMPLOYEES INTERNATIONAL UNION ENDORSED THE BAN ON DISCRIMINATION PROPOSED IN LAST FALL'S BILL. CURRENTLY, SIX STATES PROHIBIT ANY DISCRIMINATION IN ADMISSIONS. ANOTHER OPTION IS TO ESTABLISH A STATISTICAL MEASURE OF DISCRIMINATION THAT PROHIBITS HOMES FROM TAKING MORE PRIVATE-PAY PATIENTS ABOVE A CERTAIN THRESHOLD (E.G., 10% ABOVE THE STATE-WIDE AVERAGE PERCENT MEDICAID). A LEVEL HIGHER THAN THE STATE-WIDE AVERAGE IS NECESSARY BECAUSE THOSE FIGURES ARE ARTIFICIALLY LOW -- DUE TO THE CURRENT DISCRIMINATION.

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[2] CONTEMPORARY ADMINISTRATOR SURVEY, 1984.

MEDICAID'S GOAL IS TO ASSURE BENEFICIARIES ACCESS TO APPROPRIATE CARE, A GOAL THAT CANNOT BE REALIZED IN THE CURRENT ENVIRONMENT WHERE DISCRIMINATION IS WIDESPREAD. WE MUST NOT ALLOW THE NURSING HOME INDUSTRY TO CONVERT OUR NATION'S NURSING HOMES INTO EXCLUSIVE CLUBS FOR THE WEALTHY.

### NURSE AIDE TRAINING

OUR NURSE AIDES WANT MORE TRAINING. THEY REALIZE THE HEAVY BURDEN PLACED ON THEIR SHOULDERS FOR PROVIDING VIRTUALLY ALL THE HANDS-ON PATIENT CARE. THEY ALSO SEE NURSE AIDE TRAINING AS A WAY TO MAKE HOMES BETTER PLACES TO WORK AND LIVE, TO ADVANCE THEIR CAREERS, AND TO MAKE A DECENT LIVELIHOOD.

SADLY, MOST NURSE AIDES -- IN ADDITION TO BEING FORCED IN THE MAJORITY OF NURSING HOMES TO WORK AT THE MINIMUM WAGE -- HAVE NEVER HAD THE BENEFIT OF ANY TRAINING.

A MAJORITY OF STATES STILL DON'T REQUIRE TRAINING. AND, WHERE PROGRAMS EXIST, THEIR CALIBER IS HIGHLY UNEVEN. AT LAST COUNT, 17 STATES SET SOME MINIMUM HOURS FOR NURSE AIDE TRAINING -- RANGING FROM 19 HOURS (2.3 DAYS) UP TO 300 HOURS (3.5 WEEKS).

IN-SERVICE TRAINING PROGRAMS OFFERED BY EMPLOYERS AT THE WORKPLACE OCCUR HAPHAZARDLY, AND OFTEN ARE JUST ORIENTATION PROGRAMS. THE SAD REALITY IS THAT MOST NURSE AIDES RECEIVE ONLY THE TRADITIONAL ON-THE-JOB TRAINING, SUPERVISED BY OTHER INEXPERIENCED NURSE AIDES.

FOR EXAMPLE, A RECENT SURVEY OF 45 NURSING HOMES IN MILWAUKEE COUNTY, CONDUCTED BY OUR WISCONSIN LOCAL UNION, FOUND THAT ONLY 27% OF THE NURSING HOMES SURVEYED HAVE NURSE AIDE TRAINING PROGRAMS. MOREOVER, ONLY ONE-THIRD OF THOSE WITH TRAINING PROGRAMS OFFERED TWO WEEKS OR MORE TRAINING. AT THE SAME TIME, MOST OF THE "TRAINEES" HAD TO PERFORM JOB DUTIES, FURTHER DILUTING THE ACTUAL TRAINING.

IN CONTRAST TO WISCONSIN, MORE MICHIGAN NURSING HOME OPERATORS OFFER SOME TRAINING BECAUSE STATE REGULATIONS REQUIRE EMPLOYERS TO VERIFY THAT AIDES ARE COMPETENT TO PROVIDE CARE. HOWEVER, THERE ARE NO SPECIFIC STANDARDS ON THE CONTENT OF THESE PROGRAMS, THE LENGTH OF TRAINING OR THE QUALIFICATIONS OF INSTRUCTORS.

WHILE MORE EMPLOYERS PROVIDE SOME TRAINING, THE INTENSITY AND QUALITY OF THE TRAINING IS GENERALLY POOR, A FACT CONFIRMED BY THE RECENT SEIU LOCAL UNION SURVEY OF MICHIGAN'S NURSING HOME CARE. (A COPY OF THE SURVEY FINDINGS IS ATTACHED TO THIS TESTIMONY.)

ONLY 16% OF NURSE AIDES RATED THEIR TRAINING PROGRAM AS GOOD. MOREOVER, THE LENGTH OF TRAINING VARIED WIDELY AMONG FACILITIES, ALTHOUGH MOST WERE LESS THAN TWO WEEKS. FULLY 75% OF THE AIDES WERE PUT ON THE FLOOR PRIOR TO COMPLETING TRAINING IN WIDESPREAD VIOLATION OF THE LETTER AND SPIRIT OF MICHIGAN LAW.

MOST STARTLING, HOWEVER, IS THE FINDING THAT AN OVERWHELMING MAJORITY OF THE RESPONDENTS (74%) SAID THAT NURSE AIDES SUPERVISE THE CLINICAL EXPERIENCE OF NEW TRAINEES.

FOR THESE REASONS, SEIU APPLAUDS H.R. 2270'S REQUIREMENT FOR MANDATORY NURSE AIDE TRAINING. SEIU ALSO SUPPORTS THE BILL'S NEW REQUIREMENTS FOR FEDERALLY-MANDATED MINIMUM TRAINING STANDARDS, STATE APPROVAL OF THE TRAINING PROGRAMS, AND REGULAR IN-SERVICE TRAINING. NURSE AIDE TRAINING WILL GO A LONG WAY TOWARD IMPROVING THE COMFORT AND CARE OF OUR ELDERLY.

HOWEVER, WE MUST EXPRESS RESERVATIONS ABOUT THE BILL'S APPROACH TO NURSE AIDE TRAINING PROGRAMS FOR FACILITY-PROVIDED INSTRUCTION. WHERE NURSING FACILITIES PROVIDE THE TRAINING, H.R. 2270 PROVIDES THAT STATES MUST DETERMINE WHETHER AN INDIVIDUAL WHO HAS COMPLETED THE PROGRAM IS COMPETENT TO PROVIDE PATIENT CARE.

WE ARE PREPARED TO WORK THROUGH EMPLOYER-PROVIDED TRAINING PROGRAMS AS LONG AS THEY DO NOT REQUIRE COMPETENCY TESTING OF EMPLOYEES.

WE BELIEVE THAT LEGISLATION REQUIRING TESTING OF NURSE AIDES IS PREMATURE IN LIGHT OF OUR EXPERIENCE WITH EMPLOYER-BASED TRAINING PROGRAMS. THE INSTITUTE OF MEDICINE REPORT STATES:

> "THERE IS NO CLEAR EVIDENCE AT PRESENT OF THE AMOUNT OF TIME AND THE CONTENT OF THE MOST EFFECTIVE NURSE AIDE TRAINING PROGRAMS."

CERTIFICATION OF NURSE AIDES IS OUR GOAL, BUT WE DON'T YET HAVE ENOUGH DEVELOPMENT OF PROGRAMS ON WHICH TO TEST THE COMPETENCY OF WORKERS. WE FEEL CONGRESS SHOULD NOT MOVE FORWARD ON CERTIFICATION UNTIL EFFECTIVE TRAINING PROGRAMS ARE IN PLACE.

FLORIDA'S EXPERIENCE WITH A NURSE AIDE TESTING PROGRAM SHEDS SOME LIGHT ON THE PROBLEM. CURRENTLY,THE FAIL RATE IS A WHOPPING 92% BECAUSE THE TEST IS WEIGHTED TOWARD READING AND WRITING SKILLS RATHER THAN CLINICAL SKILLS.

IN THE INTERIM WE BELIEVE THAT TRAINING PROGRAMS CAN BE STRENGTHENED BY ASSURING THAT:

- EMPLOYEES AND THEIR REPRESENTATIVES AND CONSUMER GROUPS CAN WORK WITH STATES AND EMPLOYERS TO DESIGN TRAINING PROGRAMS THAT ARE REALISTICALLY RELATED TO THE ACTUAL DUTIES PERFORMED;
- INSTRUCTORS QUALIFICATIONS ARE ESTABLISHED BY THE STATE;
- THE EMPLOYER OR OTHER TRAINING FACILITY IS HELD ACCOUNTABLE FOR THE QUALITY OF THE TRAINING PROGRAM THROUGH PERIODIC INSPECTIONS OF THE PROGRAM; AND
- APPROPRIATE SAFEGUARDS FOR EXISTING EMPLOYEES ARE BUILT IN.

EMPLOYEE SAFEGUARDS ARE NECESSARY SINCE COMPLETION OF TRAINING IS A REQUIREMENT FOR CONTINUED EMPLOYMENT. OTHERWISE, WORKERS COULD BE HARASSED BY EMPLOYERS BASED ON PATIENT-CARE WHISTLE BLOWING OR UNION ACTIVITIES. SUGGESTIONS INCLUDE GIVING EMPLOYEES AT LEAST TWO OPPORTUNITIES TO COMPLETE THE COURSE AND SETTING UP A STATE APPEALS PROCESS TO ARBITRATE DISPUTES.

AS A FINAL NOTE, THE COST FOR TRAINING MUST BE MEDICAID-REIMBURSABLE (I.E., A PASS-THROUGH). IF HOMES ARE NOT REIMBURSED, THEY MAY FORCE WORKERS TO PAY FOR SUCH TRAINING.

ALREADY THIS COST-SHIFTING IS PREVALENT. THE INDUSTRY CLAIMS THAT NURSE AIDE TRAINING PROGRAMS ARE EXPENSIVE. YET, EMPLOYERS ARE SKIRTING THE MINIMUM WAGE LAW BY OFFERING TRAINING TO JOB APPLICANTS RATHER THAN "EMPLOYEES". THIS PRACTICE TRANSFERS THE TRAINING COSTS TO WORKERS, BECAUSE THEY DON'T HAVE TO BE PAID. ALSO, SINCE "TRAINEES" PERFORM ON-THE-JOB DUTIES AS PART OF TRAINING, THE OPERATORS GET "FREE LABOR".

FOR EXAMPLE, AMERICAN MEDICAL SERVICES IN WISCONSIN REQUIRES THREE WEEKS OF TRAINING. POTENTIAL EMPLOYEES IN TRAINING GET NO WAGE NOR EVEN A JOB GUARANTEE. AFTER GRADUATION -- IF THEY ARE OFFERED A JOB -- THEY EARN $4 AN HOUR.

THE MICHIGAN SURVEY LIKEWISE FOUND THAT 30% OF THE NURSE AIDES WERE NOT PAID DURING THEIR TRAINING AND 12% HAD TO PAY OUT-OF-POCKET FOR THE PRIVILEGE OF BEING TRAINED -- WITHOUT A JOB GUARANTEE. BEVERLY ENTERPRISES ALSO HAD ITS APPLICANTS PURCHASE A UNIFORM.

THIS IS OUTRAGEOUS AND ENCOURAGES EMPLOYERS TO FIRE THE EXISTING WORKFORCE. WE RECOMMEND THAT THE BILL SPECIFICALLY APPLY THE TRAINING REQUIREMENT TO "EMPLOYEES" OR "INDIVIDUALS IMMEDIATELY UPON EMPLOYMENT" SO THAT THE FEDERAL MINIMUM WAGE LAW APPLIES.

## STAFFING LEVELS

NURSING HOME WORKERS FEEL THAT STAFFING LEVELS ARE A CRITICAL INGREDIENT FOR QUALITY PATIENT CARE. YOU CAN MANDATE TRAINING, BUT WITHOUT ENOUGH PEOPLE, CONSCIENTIOUS AND COMPLETE NURSING HOME CARE IS IMPOSSIBLE.

SUFFICIENT STAFFING MEANS SIMPLY HAVING ENOUGH PEOPLE TO PROVIDE THE BASIC KINDS OF CARE ESSENTIAL TO RESIDENTS' HEALTH AND WELL-BEING, SUCH AS FEEDING, TOILETING, AND BATHING, AS WELL AS THE TENDER LOVING CARE NEEDED FOR THEIR EMOTIONAL HEALTH.

THE MICHIGAN PATIENT CARE SURVEY FOUND SHORT-STAFFING TO BE THE RULE, NOT THE EXCEPTION. FULLY 77% OF THE RESPONDENTS REPORTED THAT SHORT-STAFFING IS "OFTEN" A PROBLEM AT THEIR FACILITY, AND 21% MORE RESPONDED THAT IT IS "SOMETIMES" PROBLEMATIC.

CHRONIC SHORT-STAFFING IN MICHIGAN NURSING HOMES IS FURTHER CONFIRMED BY ROUTINE STAFF-TO-PATIENT RATIOS BELOW THE MINIMUM STANDARDS REQUIRED BY THE STATE. BETWEEN 62%-74% OF THE SURVEYED FACILITIES DO NOT MEET THE MINIMUM LEVELS ON ONE OR MORE SHIFTS.[3]

NEW INDUSTRY STAFFING PRACTICES THREATEN TO FURTHER UNDERMINE EXISTING MINIMUM STANDARDS.

FOR EXAMPLE, HILLHAVEN CORPORATION IN NORTHERN CALIFORNIA PROPOSES TO STAFF UP DURING "PEAK HOURS". UNDER THIS PLAN, ONE 8 HOUR SHIFT WOULD BE ELIMINATED. IN ITS PLACE, WOULD BE TWO 4 HOUR SHIFTS; ONE DURING THE MORNING AND ANOTHER SHORT SHIFT IN THE EVENING, SO THE HOME WOULD HAVE ENOUGH STAFF FOR PEAK HOURS TO COVER FEEDING AND BATHING SCHEDULES. SINCE NO NEW WORKERS WOULD BE HIRED, THIS MEANS CHRONIC UNDERSTAFFING DURING NON-PEAK HOURS -- ESPECIALLY FROM 10:00 A.M. UNTIL 3:00 P.M.

ANOTHER LARGE NURSING HOME CHAIN -- BEVERLY ENTERPRISES -- DELIBERATELY SETS ITS STAFFING PATTERNS TO MEET BARE-MINIMUM WEEKLY STAFFING STANDARDS. OUR SURVEY SHOWS THAT BEVERLY FACILITIES IN

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[3] THE NURSE AIDE TO PATIENT RATIOS FOR THE DAY, AFTERNOON, AND MIDNIGHT SHIFTS EXCLUDE RNs AND SO UNDERESTIMATE ACTUAL NURSING TO PATIENT LEVELS. HOWEVER, THE SURVEY FINDS THAT NURSE AIDES PROVIDE THE OVERWHELMING MAJORITY OF DIRECT PATIENT CARE.

MICHIGAN TEND TO STAFF AT LEVELS 10% BELOW EVEN THE AVERAGE FOR PROPRIETARY HOMES.[4] IN 11 COUNTIES, THEY OPERATE THE VERY LOWEST-STAFFED HOMES.

NATIONWIDE, THE INSTITUTE OF MEDICINE STUDY FOUND NURSING HOME STAFFING TO BE ALREADY DANGEROUSLY BELOW LEVELS NEEDED TO PROVIDE EVEN MINIMAL PATIENT CARE. THEY CALLED ON THE INDUSTRY TO MAKE RAISING STAFFING LEVELS ITS TOP PRIORITY.

THE BILL'S REQUIREMENT FOR IMPROVED NURSING COVERAGE IS A SIGNIFICANT STEP IN ADDRESSING THE STAFFING ISSUE. THIS WILL HELP, ESPECIALLY IN IMPROVING SUPERVISION OF NURSE AIDES. BUT IT DOESN'T GO FAR ENOUGH. WE URGE YOU TO ASK THE INSTITUTE OF MEDICINE TO STUDY THE STAFFING OF NURSING HOMES. SUCH A STUDY SHOULD RELATE MINIMUM NURSING STAFF LEVEL REQUIREMENTS (LICENSED NURSES AND NURSE AIDES) TO RESIDENT ACUITY. THE RESULTS COULD FORM THE BASIS FOR SETTING FEDERAL MINIMUM STAFFING STANDARDS.

## CONCLUSION

IN SHORT, H.R. 2270 MARKS A GIANT STEP FORWARD IN LONG-OVERDUE EFFORTS TO UPGRADE THE QUALITY OF CARE IN OUR NATION'S NURSING HOMES. THIS BILL FILLS MAJOR GAPS BY ENDING DISCRIMINATION IN SERVICES AND BY PROVIDING FOR RESIDENT ASSESSMENTS, NURSE AIDE TRAINING, UNANNOUNCED INSPECTIONS, AND AN ARRAY OF NEW SANCTIONS. SEIU BELIEVES THAT FURTHER IMPROVEMENTS -- ESPECIALLY EVEN TOUGHER

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[4] IBID., SEIU, "BEVERLY ENTERPRISES IN MICHIGAN", PAGES 4-7.

ANTI-DISCRIMINATION ADMISSIONS POLICIES AND PERIODIC STATE MONITORING OF EMPLOYER-PROVIDED NURSE AIDE TRAINING PROGRAMS -- WILL GREATLY ENHANCE THE QUALITY OF NURSING HOME CARE.

I WANT TO TELL YOU, FRANKLY, THAT I BELIEVE ALL ATTEMPTS TO PROVIDE HIGH QUALITY NURSING CARE ARE, IN PART, DOOMED UNTIL WE ADDRESS THE ISSUE OF FAIR WAGES. THE ISSUES OF WAGES AND QUALITY PATIENT CARE ARE INEXTRICABLY TIED TOGETHER IN THE HEALTH CARE INDUSTRY. LOW WAGES AND INADEQUATE BENEFITS ARE A RECIPE FOR HIGH TURNOVER. AND THE CONSTANT CHANGES OF STAFF WITH LITTLE EXPERIENCE IN NURSING HOMES, MEAN LITTLE "CONTINUITY OF CARE" FOR ELDERLY PATIENTS. THIS IS THE KEY INGREDIENT IN PROVIDING QUALITY CARE FOR THE ELDERLY.

THANK YOU. I'D BE HAPPY TO ANSWER ANY QUESTIONS YOU HAVE AT THIS TIME.

TABLE 1. SELECTIVE FINANCIAL DATA ON TOP NURSING HOMES COMPANIES

| COMPANY | BEDSIZE | AFTER-TAX PROFIT MARGIN 1986 | 1985 | 1984 | 1983 | OPERATING PROFIT MARGIN 1986 | 1985 | 1984 | 1983 | PERCENT OF REVENUE FROM MEDICAID 1986 | 1985 | 1984 | 1983 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Beverly Enterprise | 121,800 | 2.2% | 3.5% | 3.3% | 3.2% | 13.1% | 16.2% | 15.6% | 14.3% | 59.0% | 59.0% | 59.0% | 63.0% |
| Hillhaven Corp. | 43,949 |  | 3.6% | 2.9% | 2.5% |  | 26.0% | 25.0% | 23.2% | 52.6% | 53.3% | 54.6% | 57.0% |
| Manor Care Inc. | 18,105 | 7.9% | 6.9% | 6.5% | 3.6% | 20.1% | 19.2% | 19.2% | 18.6% | 23.0% | 25.0% | 22.0% | 26.0% |
| Owens-Illinois Inc.<br>(Hlth Care & Retire't Corp of Am) | 16,000 | 10.0% | 12.8% | 6.9% | 6.5% |  |  | 20.4% | 18.1% |  |  | 61.0% | 60.0% |
| Unicare Health Facility Inc. | 14,100 | 2.7% | 1.8% | 1.1% | 0.8% | 13.0% | 12.1% | 11.4% | 11.2% | 49.0% | 50.0% | 49.0% | 51.0% |
| Care Enterprises Inc. | 12,025 |  | 1.5% | 2.2% | 1.0% | 12.0% | 13.5% | 12.0% | 11.2% | 53.0% | 55.0% | 57.0% | 61.0% |
| National Health Corp. | 6,851 | 6.0% | 8.5% | 4.7% | 3.0% | 20.1% | 19.7% | 16.2% | 15.6% | 56.0% | 57.0% | 59.0% | 58.0% |
| Summit Health LTD. | 6,406 |  | 5.1% | 4.9% | 4.4% |  | 23.6% | 24.4% | 22.7% |  | 57.0% | 55.0% | 62.0% |
|  | .......... | ...... | ....... | ....... | ....... | ....... | ....... | ....... | ....... | ....... | ....... | ....... | ....... |

* Health Care and Retirement Corp. of America before merger with Owens-Illinois

SERVICE EMPLOYEES
INTERNATIONAL UNION, AFL-CIO, CLC
MICHIGAN COUNCIL 35

# MICHIGAN NURSING HOME
# PATIENT CARE SURVEY

Conducted by
SEIU Local 79

March 4, 1987

2604 FOURTH STREET • DETROIT, MICHIGAN 48201 • (313) 965-9450
419 S. WASHINGTON • LANSING, MICHIGAN 48933 • (517) 482-4886
RICHARD W. CORDTZ, *President*

## SEIU LOCAL 79 NURSING HOME PATIENT CARE SURVEY

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### TRAINING

1. How much training are nurse aides given before they officially start?

| | None | 1-3 Days | 4-5 Days | 6-9 Days | 10-19 Days | 20+ |
|---|---|---|---|---|---|---|
| Classroom | 17 13% | 47 37% | 27 21% | 11 9% | 22 17.5% | 2 1.5% |
| Floors | 9 7% | 61 48% | 30 24% | 11 8% | 14 11% | 2 1% |

2. Are new nurse aides ever given regular assignments before they have completed training?

NEVER 38 (25%)

SOMETIMES 75 (50%)

OFTEN 38 (25%)

THE RESPONSE TO THIS QUESTION INDICATES WIDESPREAD VIOLATIONS OF BOTH THE LETTER AND SPIRIT OF MICHIGAN REGULATIONS WITH RESPECT TO TRAINING. RULE 2002 STATES THAT EMPLOYEES MUST BE VERIFIED AS "COMPETENT TO PERFORM ALL ASSIGNED TASKS PRIOR TO THE TIME THE EMPLOYEE IS ASSIGNED TO PERFORM THEM..." ONE EXPLANATION FOR THIS SITUATION MAY BE THAT MANY NURSING HOMES ARE SO SHORT-STAFFED THAT THEY RUSH NEW HIRES ONTO THE FLOOR SO THAT THEY MAY BE COUNTED FOR STAFFING PURPOSES. (THE LAW ALLOWS ANY NEW HIRE TO BE COUNTED AS MEETING THE STAFFING REQUIREMENTS).

3. Who provides training for new aides?

| | DON | In-serv. | Direc. | RNs/LPNs | Aides | Other |
|---|---|---|---|---|---|---|
| Classroom | 29 25% | 42 36% | 18 15.5% | 10 8.5% | 14 12% | 3 2.5% |
| Floors | 9 | 5 | 2 | 2 | 53 74% | 1 |

THE ANSWERS INDICATE THAT CLASSROOM TRAINING IS PROVIDED MOSTLY BY TRAINED AND LICENSED PERSONNEL, THOUGH 12% INDICATED THAT NURSE AIDES PROVIDE CLASSROOM TRAINING AT THEIR FACILITIES. WHAT IS STARTLING, HOWEVER, IS THAT AN OVERWHELMING MAJORITY (74%) INDICATE THAT ON-THE-JOB TRAINING IS PROVIDED BY NURSE AIDES. THIS FIGURE IS CONFIRMED BY THE NEXT QUESTION:

4. Are nurse aides expected to provided on the job training for new hires?

YES 136 (90%)

NO 15 (10%)

Local 79 Patient Care Survey, Page 2

5. Are nurse aides paid during their training?

YES 105 (70%)

NO 44 (30%)

6. Do nurse aides have to pay for their training?

YES 18 (12%)

NO 134 (88%)

WHILE THE RESPONSES INDICATE THAT MOST EMPLOYEES ARE PAID DURING TRAINING AND ARE NOT REQUIRED TO PAY FOR THEIR TRAINING, IT IS DISTURBING THAT ANY EMPLOYEES WOULD WORK FOR FREE OR, WORSE, BE REQUIRED TO PAY FOR THE PRIVILEGE OF BEING TRAINED, PARTICULARLY CONSIDERING THAT IT APPEARS THAT NURSE AIDES PROVIDE THE BULK OF TRAINING. NURSE AIDES ARE NORMALLY NOT PAID A PREMIUM FOR TRAINING DUTIES.

10. How would you rate training/orientation programs at your facility?

GOOD 25 (16%)

FAIR 65 (42%)

POOR 65 (42%)

ONLY 16% RATE TRAINING PROGRAMS AS GOOD.

## STAFFING

1. Is short staffing a problem at your facility?

OFTEN 121 (77%)

SOMETIMES 33 (21%)

NEVER 3 (2%)

2. How many patients are aides normally responsible for?

| | | | | | |
|---|---|---|---|---|---|
| | 1-4 | 5-7 | 8 | 9-11 | 12 or more |
| DAYS | 2 2% | 8 7% | 31 28% | 46 42% | 22 20% |
| | 1 to 8 | 9 to 11 | 12 | 13 to 15 | 16 or more |
| AFT. | 11 (10%) | 8 (7%) | 17 (15.5%) | 31 (28%) | 42 (385.%) |
| | 1 to 12 | 13 to 14 | 15 | 16 to 18 | 19 or more |
| MID. | 5 (5%) | 5 (5%) | 15 (15%) | 36 (36%) | 38 (38%) |

STATE NURSING HOME REGULATIONS SET NURSING PERSONNEL TO PATIENT RATIOS FOR DAYS, AFTERNOONS, AND MIDNIGHTS AT 1 TO 8, 1 TO 12, AND 1 TO 15. THOUGH THE ABOVE REFLECTS ONLY AIDE TO PATIENT RATIOS, THE MAJORITY OF RESPONSES FOR ALL THREE SHIFTS INDICATES THAT AIDES ARE REGULARLY ASSIGNED

PATIENT LOADS IN EXCESS OF WHAT THE STATE INTENDED TO BE AN REASONABLE PATIENT LOAD. 62% INDICATED DAY SHIFT PATIENT LOADS IN EXCESS OF 8 PATIENTS: 66% INDICATED AFTERNOON SHIFT LOADS IN EXCESS OF 12 PATIENTS: AND 74% INDICATED MIDNIGHT SHIFT LOADS IN EXCESS OF 15 PATIENTS. THIS TYPE OF STAFFING CREATES A SITUATION WHERE CONSCIENTIOUS AND COMPLETE PATIENT CARE IS IMPOSSIBLE, AS REFLECTED BY THE RESPONSE TO THE NEXT QUESTION:

5. Are there things you don't get finished because you are short staffed?

YES 132 (86%)

NO 21 (14%)

SOME MAY ARGUE THAT THE RESPONSE TO QUESTION 2 DOES NOT TAKE INTO CONSIDERATION THAT NURSES ARE COUNTED IN THE STATE RATIOS AND DO PERFORM PATIENT CARE DUTIES. RESPONSES TO THE FOLLOWING QUESTION INDICATE THAT NURSING ASSISTANTS PROVIDED AN OVERWHELMING PROPORTION OF DIRECT HANDS-ON PATIENT CARE, AND SHARE SUBSTANTIALLY IN ALMOST ALL PATIENT CARE DUTIES.

6. Please indicate which nursing staff members perform the following tasks:

| | NURSES | NURSE AIDES | BOTH |
|---|---|---|---|
| Charting | 46 (31%) | 10 (7%) | 92 (62%) |
| Passing Medications | 134 (94%) | 1 (1%) | 8 (5%) |
| Training Staff | 17 (12%) | 72 (50%) | 54 (38%) |
| Supervising staff | 121 (89%) | 4 (3%) | 11 (8%) |
| Taking vital signs | 15 (10%) | 78 (53%) | 54 (37%) |
| Bathing/dressing | 1 (.5%) | 149 (94%) | 9 (5.5%) |
| Feeding | 1 (1%) | 137 (89%) | 15 (10%) |
| Turning | 0 | 142 (93%) | 10 (7%) |
| Toileting | 1 (1%) | 143 (95%) | 7 (5%) |
| Making beds | 0 | 146 (96%) | 6 (4%) |
| Caring for clothing/ personal belongings | 3 (3%) | 127 (91%) | 9 (6%) |
| Oral care | 1 (1%) | 139 (93%) | 10 (6%) |
| Dressing wounds | 64 (45%) | 20 (14%) | 56 (40%) |
| Physical therapy | 14 (15%) | 55 (56%) | 29 (29%) |
| Recreational activities | 9 (11%) | 54 (63%) | 22 (26%) |
| Passing water | 3 (2%) | 139 (93%) | 8 (5%) |
| Routine treatments | 58 (44%) | 44 (34%) | 29 (22%) |

THESE FIGURES CLEARLY SHOW THAT A STAFFING PROBLEM IS A NURSE AIDE STAFFING PROBLEM. WORSE YET, IN ADDITION TO PROVIDING MOST DIRECT PATIENT CARE ALONE, AND SHORT HANDED, NURSE AIDES ARE ROUTINELY ASSIGNED CHORES OUTSIDE OF THEIR NORMAL NURSING DUTIES. THESE ASSIGNMENTS MAY BE IN VIOLATION OF STATE LAW. WHATEVER THE CASE, THEY

EXACERBATE AN ALREADY IMPOSSIBLE WORKLOAD SITUATION FOR NURSE AIDES.

7. Are nurse aides required to do housekeeping, laundry, or dietary chores?

| | |
|---|---|
| OFTEN | 79 (51%) |
| SOMETIMES | 47 (30%) |
| NEVER | 28 (18%) |

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Other patient care problems cited by Local 79's stewards were these:

| | |
|---|---|
| Lack of supplies | 85 (53%) |
| Shortage of linens | 115 (72%) |
| Bed sores | 48 (30%) |
| Poor infection control procedures | 72 (45%) |
| Problems with food/meals | 51 (32%) |
| proper handling of medications | 30 (19%) |

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Number of surveys mailed out: 448

Number of surveys returned: 159 (35%)

Number of facilities responding: 97

Responses by job classification:
LPN's--1
Nurse Aides--137
Dietary aides/cooks--7
Housekeeping/Laundry--14

Mr. WAXMAN. Thank you very much, Mr. Sweeney.

Dr. Harrington.

### STATEMENT OF CHARLENE HARRINGTON

Ms. HARRINGTON. Good morning, Mr. Chairman, I am Charlene Harrington associate professor and associate director of the Institute for Health and Aging at the University of California at San Francisco, and former director of Licensing and Certification for the State of California, and a member of the Institute of Medicine's Committee to study Nursing Home Regulation.

I am pleased to appear before the committee on behalf of the American Nurses' Association and its 188,000 members to discuss our concerns regarding H.R. 2270. I am accompanied by Tom Nickels, the ANA's legislative director.

H.R. 2270 contains provisions that we believe will improve the quality of life for those who reside in nursing homes. Briefly I would like to mention four such provisions.

One, the ANA supports a number of the provisions related to nurse training. The requirements that nurses aides must undergo a training program and demonstrate competency prior to providing services represent a positive step for the improved care. Inservice training and regular performance reviews will greatly enhance the quality of care that nursing assistance provide.

Second, the inclusion of a resident's assessment program is a vital component of the legislation. High quality of care is dependent upon careful assessment of each individual's physical, mental, and social status. We concur with the provision of H.R. 2270 which mandates that a registered nurse be the individual responsible for coordination of the assessment.

To make the resident assessment reflect the resident's, patient care needs, it is critical that such assessments be conducted upon entry to the facility, and every 3 months thereafter, and at any sign of a significant change in the patient's condition.

Third, we commend the sponsors for addressing the issue of discrimination against individuals who must rely upon public financing. While all those residing in nursing homes will be assured equity in terms of bed holds and transfers, H.R. 2270 does not address the need for protection against discrimination or admission to the nursing home.

Current practices which favor self-paying residents over those who must rely upon Medicaid are inequitable. We urge the committee to reconsider this provision.

Four, the ANA strongly supports the elimination of the SNF, ICF distinction in this legislation. As the IOM report pointed out, a survey on a State-by-State basis showed that there was a negligible difference in the level of care needed by patients in either an SNF or an ICF facility.

Mr. Chairman, regrettably we believe that one of the most important reforms needed in improving the quality of care for nursing home residents is missing from this legislation. We must focus on the primary reason residents are in nursing homes, that is, that they're there to receive nursing care. It is our view that true quality of care cannot be delivered without adequate staffing.

The IOM study stated that one of the major factors affecting quality of care and quality of life in nursing homes is both the number and the quality of nursing staff. This study affirmed that adequate nurse staffing should be the top priority issue in nursing homes. Quality of care cannot be provided without at least having one R.N. on duty to supervise, deliver, and evaluate nursing care.

There is a long history of under staffing in nursing homes. According to the IOM study: "Staffing patterns vary across the country, but for the most part there are inadequate numbers of nurses to provide minimum care needed."

And we are experiencing an increase in the aging population; in the number of patients that need skilled nursing care as a result of prospective payment; and in the number of frail elderly with multi chronic conditions who need nursing care.

All of these factors increase the need for increasing the registered nurse staffing levels in nursing homes.

H.R. 2270 provides for R.N. coverage on the day shift only in SNF and ICF facilities. This would result in patients not receiving R.N. care two-thirds of the time. The ANA believes that at a minimum, at least one registered nurse should be on duty in all nursing homes on a 24-hour per day basis, 7 days a week in order to address the needs of the patients.

We believe that this additional requirement would cost the Federal Government approximately $20 million. Such a provision must be a component of H.R. 2270 if the bill is to accomplish its primary purpose, which is to improve both the quality of care in the daily lives and the health status of the residents.

This position is supported by over 20 consumer and provider organizations including the National Citizens Coalition for Nursing Home Reform, and the AARP.

Again, we commend you for sponsoring this proposal. We feel that H.R. 2270 will greatly enhance the quality of health care in nursing homes, but we believe the bill does not go far enough in addressing adequate staffing. If we want to ensure true quality, we must provide sufficient registered nursing resources.

Thank you.

[Testimony resumes on p. 383.]

[The prepared statement of Ms. Harrington follows:]

# TESTIMONY
# of the
# AMERICAN NURSES' ASSOCIATION

Mr. Chairman, I am Charlene Harrington, Associate Director of the Institute for Health and Aging at the University of California at San Francisco. I was also a member of the committee that generated the Institute of Medicine's (IoM) report, Improving the Quality of Care in Nursing Homes, which in part, has generated congressional interest in this issue. I appear today on behalf of the American Nurses' Association (ANA) and its 188,000 members to present our views on the issue of nursing home reform, and the proposals embodied in H.R. 2270, the "Medicaid Nursing Home Quality Care Amendments of 1987." We are acutely aware of the need for reform in several key aspects of long-term institutional health care delivery, and we commend the Congress for commissioning the Institute of Medicine's (IoM) report on improving the quality of care provided in nursing homes.

## BACKGROUND

In May 1981, the Health Care Financing Administration (HCFA) proposed a relaxation of certain requirements of the certification process which nursing homes must undergo in order to certify their eligibility for payment and participation in the Medicare and Medicaid programs. This movement toward deregulation of the nursing home industry was due in part to the Administration's belief that less federal intervention would allow the market to set new standards for the availability of services as well as the quality of care. The nursing home industry generally supported this goal of easing annual inspection and certification requirements for facilities with a good record of compliance.

However, consumer groups, state agencies, and some health care provider organizations, including the ANA, strongly opposed the recommendations proposed by HCFA. In particular, efforts to change staffing requirements met strong opposition by the health care community.

HCFA abandoned several of its more contentious proposals after a public outcry. Subsequent regulations issued in 1982 would have reduced the frequency of provider surveys, reduced subsequent inspections for nursing homes that had a poor record of compliance, and shifted the responsibility of government oversight to the Joint Commission on the Accreditation of Hospitals.

Partially as a result of HCFA's efforts to lessen the regulatory responsibilities of providers, the Congress imposed a ten month moratorium on the implementation of regulatory proposals. In addition, Congress ordered HCFA to meet further with regulators, providers, and consumers to develop a mutually agreed upon method to improve the survey process.

During the ten month moratorium, a coalition of providers, health care organizations, nursing home residents, and consumer groups developed A Consumer Statement of Principals for the Nursing Home Regulatory System, which was coordinated under the leadership of the National Citizens' Coalition for Nursing Home Reform. This policy statement, endorsed by forty-four national organizations, urged the incorporation and development of a survey process that focused upon actual patient outcomes rather than an analytical estimation of a facility's ability to provide proper care for nursing home residents.

At the end of the moratorium, HCFA contracted with the Institute of Medicine to conduct a study of nursing home regulation, which took 22 months to complete. This study, and subsequent legislation introduced by Mr. Dingell and Mr. Waxman, H.R. 2270, are the focus of our comments today.

COMMENTS ON MAJOR PROVISIONS

Provisions of Registered Nursing Services

Nursing is the basic unit of care in nursing homes. The quality of care in a nursing home is directly dependent upon the presence of an adequate number of registered nursing staff to assess, plan, provide, and evaluate the care requirements of each resident. Registered nurses are the most appropriate health providers to assure safety, comfort, and maximum utilization of family resources to the advantage of patients, while at the same time providing high-technology therapies, rehabilitation, and management of chronic disease.

While currently 80-90 percent of the direct care in nursing homes is provided by nursing assistants, these assistants cannot substitute for registered nurses. According to standards of practice, registered nurses in nursing homes are legally and ethically accountable for nursing care delivered in these settings. This responsibility includes the care provided by the nursing assistants. Moreover, the implementation of the prospective payment system in the acute care setting, with earlier discharges, has resulted in more acutely ill patients being admitted with more complex needs. These increased levels of patient acuity with the accompanying increased demand for hi-tech care call attention to the need for more registered nurses in nursing homes. Nurses must possess not only the technological skills to monitor fluctuating physical conditions, along with equipment such as enteral/parenteral infusion pumps and respirators, but also make many of the critical clinical judgments relative to a patient's well-being.

As the demand for institutional long-term care continues to grow, the demand on the nursing profession correspondingly increases to meet that demand. To address this need, more staffing studies must be undertaken to develop ways to determine appropriate staffing requirements to meet the varying nursing care requirements in the nursing home population.

Therefore, ANA has made the following recommendations:

I. Regulations which address the delivery of safe and effective nursing care to nursing home patients will be based on ratios of patient care needs, hours of care needed, and numbers of registered nursing staff for the provision of safe and effective care;

II. Registered nursing services will be provided 24 hours a day, seven (7) days a week;

III. Staffing and reimbursement in nursing homes will be based on a case mix classification system accurately reflecting the intensity of patient needs;

IV. Every nursing home will have a full-time registered nurse as director of nursing who is accountable for the quality of nursing care provided in the facility;

V. In addition to the director of nursing, every nursing home will have at a minimum a registered nurse on each shift who is available to plan, discuss, and evaluate plans of care, or to provide direct care;

VI. All nursing home patients will have access to the services of clinical nurse specialists or nurse practitioners. Staffing will not be decreased during hours when the clinical nurse specialists or nurse practitioners are in the facility;

VII. Payment for the services of clinical nurse specialists or nurse practitioners will be provided, particularly with respect to the delivery of care to patients in nursing homes.

VIII. Every nursing home will make provision for a registered nurse who is responsible for staff development. Staff development programs will provide ongoing education and training based on systematic evaluation of staff learning needs.

We are concerned that H.R. 2270 has failed to provide for adequate registered nurse staffing. While the legislation elevates the RN staffing requirements of intermediate care facilities (ICFs) to those of skilled nursing facilities (SNFs), we feel that the presence of an RN on the day shift alone is inadequate in addressing the needs of nursing home residents. H.R. 2270 is a retreat from its predecessor of the 99th Congress, H.R. 5450, which mandated a minimum of one registered nurse in all facilities, 24 hours a day, seven days a week. While we are sensitive to the costs associated with such a provision, we cannot overlook the fact that nursing homes are in existence primarily to provide just that -- nursing care.

Regrettably, we believe that one of the most important reforms needed in improving the quality of life for nursing home residents is missing from the legislation. It is our view that true quality cannot be delivered without adequate staffing in both skilled nursing facilities and intermediate care facilities. Under current law, such minimum staffing requirements are sorely lacking, so that it is possible, (and too often the case) that there is not even one registered nurse in a SNF two-thirds of the time, and in an ICF virtually all the time. We cannot see how quality care can be provided to the frail elderly in nursing homes without at least one R.N. on duty to supervise, evaluate and deliver nursing care. The inclusion of a requirement that the services of a registered nurse be provided on a 24-hour-a-day basis would ensure that nursing home residents receive the necessary health care services to which they are entitled. The ANA believes that this should be a component of the legislation in order to accomplish the primary purpose of the bill, which is to enhance the quality of both the daily lives and health care status of the residents. This position is also supported by over twenty national consumer and provider associations including the National Citizens Coalition for Nursing Home Reform and the American Association of Retired Persons. Therefore we urge the subcommittee to amend H.R. 2270 to mandate around-the-clock registered nurse services in both SNFs and ICFs.

## Mandatory Training for Nursing Assistants in Nursing Homes

As stated earlier, currently 80-90 percent of the direct care provided in nursing homes is provided by nursing assistants. Many of these nursing assistants have little or no formal training, and turnover rates are high. While seventeen states have mandated training, there are no federal requirements for qualifications and training of nursing assistants. The Institute of Medicine has recommended a federal standard be established which requires that all nursing assistants complete a pre-service state approved training program.

The ANA believes that a federal standard needs to be established that requires demonstrated competency in basic nursing tasks, inter-personal communication skills, and knowledge of residents' rights prior to providing direct care to residents as nursing home employees. A pre-service training program and performance measurement mechanism would best be established and administered by organized nursing services in each facility, or in other appropriate and approved settings. The state survey for licensure of the facility should require evidence that nursing assistants have completed a preservice training program prior to delivering direct care to residents.

Registered nurses guided by the profession's standards of practice are legally and ethically accountable for the nursing care delivered, including the care provided by the nurses' designated assistants. Therefore, there should be evidence that a qualified, registered nurse is responsible for the staff development program which provides nursing assistants' training. The program shall be required by the state agency which has been given the authority to implement HCFA regulations and license the facility. In addition to the pre-service training, newly employed nursing assistants should receive an orientation to the facility and to the residents for-whom they will provide care. Specific additional training in special care areas such as Alzheimer's Units and Blind Rehabilitation Units should be provided as appropriate for the specific setting.

Ongoing continuing education and training should be provided to all nursing assistants under the supervision of a registered nurse in order to maintain, reinforce, and upgrade care-giving skills throughout employment. This should be demonstrated by regular performance measurement.

ANA supports a number of the nurse assistant training provisions included in H.R. 2270. The requirement that nurse aides must receive a training program and must be competent prior to providing nursing services is a positive step toward improved care. Although the bill states that the nurse aide does not need to complete a training program prior to delivering services, it states that the nurse assistant must be competent to provide these services. ANA would prefer that nurse assistants complete the training program and be tested for competency before providing service. It will be difficult to determine what the nurse aide is competent in if they have not completed the training. There is a fine line between completing a program and being competent to provide nursing services.

We also support regular performance reviews and regular in-service training for assistants, and the establishment by the Secretary of minimum standards for a nurse assistant training program. Both provisions will help improve the skills of nurses assistants. We would also recommend a minimum number of hours for training assistants, to be 160 hours. Also, the bill should include competency testing that demonstrates basic clinical nursing skills by nurse aides before delivering patient care. The determination of competency should be based on demonstration of basic nursing skills.

Finally, we are somewhat confused by the use of the term "nursing service personnel". We are accustomed to discussing nursing assistants or nurses' aides, rather that nursing service personnel. We are also confused as to whether this term is intended to include registered nurses and licensed practical nurses. While Section 1921 (b) (5) seems clear in this regard, Section (f) (1) does not. The subcommittee may want to consider utilizing the more traditional terminology of nurses' aides or nursing assistants rather than "nursing service personnel".

Residents' Assessments

ANA supports the provision that residents' assessments be conducted at or prior to admission, periodically, and promptly after each significant change in the resident's physical or mental condition. High quality care is dependent on the careful assessment of each resident's physical, mental, and psychological status. Since assessing a patient's health status includes the analysis and evaluation of data, and the use of independent judgement in performing the analysis and evaluation, we concur with the provision of H.R. 2270 which requires that a registered nurse be identified as the individual responsible for the coordination of the assessment. However, it is critical that residents receive continued assessments every 3 months instead of annually as indicated in the bill.

The assessment of a patient falls within the professional registered nurse's scope of practice. In determining a patient's functional, physical, mental, and psychosocial status, the following factors are assessed: normal responses to the aging process; physiological, sociological and emotional status; independent performance of activities of everyday living; perception and satisfaction with current health status; individual patterns of coping; modes of communication; health goals; and prior life-style.

It is our understanding that the intent of the resident's assessment is not just to collect data on a patient's health status, such as height and weight, but to determine a resident's change in potential health status and to make any necessary changes in the care plan and the services delivered. Such assessments demand the expertise of registered nurses, and we are pleased that the bill recognizes this fact.

Registered nurses are educated to perform careful and comprehensive assessments that are critical to the delivery of high quality care to nursing home residents. Careful assessments performed by registered nurses can, through early detection and and intervention, act to reduce compliations and possible hospitalizations. These assessments can also reduce complications and promote rehabilitation. Further, such an assessment will lead to the most efficient utilization of resources such as time, personnel, and finances. This could significantly contribute to a decrease in health care costs.

We are concerned, however, with the provisions of Section 1921 (h) (4) (A) that would penalize a registered nurse for willingly and knowingly falsifying a residents' assessment with a civil penalty of not more than $1,000. While we believe such conduct should not go unpunished, it is the facility, in the person of the administrator, who has the responsibility for the care delivered by the employees they hire. Thus, any sanctions or penalties should apply to the facility or administrator who actually controls the care provided.

Such penalties place an undue and unfair burden on the registered nurse, whose annual average salary is $19,000. The law does not normally place such heavy burdens on employees who receive such modest salaries. Also, we do not believe an individual should be penalized for actions they cannot control. A common problem in nursing homes is inadequate staffing, which is controlled by the chief executive officer or nursing home administrator. The employer/employee relationship is often characterized by pressure and intimidation. It is quite likely that pressure will be placed on registered nurses to certify residents' assessments without being given sufficient time or staff to validate the assessment. This provision is unfair to the employee, and does not place the responsibility on the individual truly in charge of the facility.

## Elimination of SNF/ICF Distinctión

Although current regulations governing the delivery of services to nursing home residents allow for a distinction between the levels of care provided in SNFs and ICFs, this distinction has been blurred to the point of rendering the differentiation between these two levels of care meaningless. While intermediate care facilities theoretically exist to serve residents' daily living needs, in many instances they are faced with residents needing a full range of nursing services, similar to those provided in a skilled nursing facility.

As the IoM study stated, when services provided at both facilities were surveyed on a state-by-state basis, it became immediately evident that there was a negligible difference in the level of residents' needs. The primary difference between a SNF and an ICF is the level of nursing care provided to the patients. SNFs, by regulation, must have a registered nurse on duty during the day shift only, while ICFs are only required to have one licensed nurse on duty during the day shift. The IoM study has shown that the presence of a registered nurse in either type of facility is necessary regardless of the distinction between an ICF and a SNF.

Presently, there is insufficient registered nurse staff to respond to the increasing intensity of patient care needs. While nursing is the acknowledged basic unit of care in nursing homes, currently less than eighty percent of the registered nurse work force supervise nursing home patients. Only 15 percent of nursing home employees are registered nurses. This translates into one (1) RN per 100 patients in nursing homes in contrast to one (1) RN per 4.5 patients in acute care facilities. Nursing home residents receive an average of 12.5 minutes of RN care per 24 hours.

Adequate delivery of care in the nursing home requires planning, direction, action, and supervision by registered nurses. Such care must include: initial and on-going assessment of the patient's physical and psychological health status; planning and implementing care either directly or through supervision of nonprofessional personnel; and evaluation and modification of the plan as indicated. Moreover, the professional nurse's role includes patient and family teaching, staff development, and management responsibility in providing nursing care.

We believe that ICFs have proliferated in part due to the fact that individual states are permitted to develop the criteria which determine whether a facility is an ICF or SNF. Subsequently, because regulations mandate that an SNF be paid more per patient than an ICF, and states understandably want to minimize their financial outlays for these services, the financial incentives to categorize a facility as an ICF are apparent and present substantial pressures upon state officials to do so.

In reality, both ICFs and SNFs care for similar patient populations with similar needs. The administrative distinctions between the two are not evidenced in real world situations. Therefore, we support the removal of this distinction in H.R. 2270 which will provide for the establishment of one level of care.

## Residents' Rights

The ANA is pleased to see a patient's bill of rights incorporated into the legislation. We believe that such basic rights as choosing one's own health care professionals and the right to be informed regarding prescribed treatments and plans of care are basic human rights that should not be infringed upon. The fact that individuals reside in nursing homes in no way lessens their basic rights as citizens.

Personal autonomy cannot be minimalized merely because an individual resides in a nursing home. Nursing home administrators have an obligation to assure a high degree of quality of life to residents. A basic sense of self esteem is essential to an individual's well being. Further, the facility should be obligated to promote a meaningful interchange among residents as well as promote as much independence and opportunity for choice as possible.

The National Citizen's Coalition for Nursing Home Reform conducted a study which solicited nursing home residents' views on quality of care. Residents responded that they place the greatest importance on qualifications, competence, attitudes, and feelings of staff. These findings indicate that residents' self image depends to a great extent upon the manner in which they are treated as individuals by the facilities' staff.

The ANA believes that protection of patient rights will require a great degree of enforcement. At times, nursing homes here compromised some of these individual rights in order to expedite responsibilities. This cannot be tolerated. No individual must be forced to sacrifice any basic human rights in order to receive institutional care. This is a critical component of the legislation; if basic rights are not assured, other provisions of the bill will be greatly diminished in their ability to raise the standards of care in a nursing home.

## Survey and Certification Process

We are pleased to see that H.R. 2270 requires a strengthening of the nursing home survey and certification process. H.R. 2270 will be instrumental in assisting HCFA to implement the new Long Term Care Survey. This newly developed survey tool shifts the emphasis of surveys away from paper compliance, which is based upon review of nursing home records, to the direct observation of residents. This will undoubtedly prove to be a superior instrument for assessing residents' health care needs as well as quality of life factors.

We would suggest that language in the bill specify members of the survey team, providing for a representative of appropriate health care and social disciplines. Registered nurses, social workers, and physicians are among those trained clinically, as well as academically, to perform the survey.

While we are pleased to note that H.R. 2270 has provided for a formalized survey and certification process, it could be strengthened in order to ensure that residents of nursing homes are provided with an adequate living environment. By incorporating the current survey system in lieu of the "Standard Survey", the patient outcome-orientation of the survey would more accurately reflect the overall quality of care provided rather than the traditional "paper compliance" procedures.

We are also concerned that there may be a hidden incentive for the standard surveys to yield positive outcomes. Because "Extended and Follow-up" surveys would only be conducted if the results of the "Standard Survey" showed that a facility had provided poor quality care, there is a financial incentive to discourage "Standard Survey" outcomes that would demonstrate the need for subsequent "Extended Surveys". By initially utilizing the existing survey system, we will help to ensure that nursing home residents are truly receiving the services to which they are entitled, and that the facility is in compliance with the other provisions embodied in H.R. 2270.

## Discrimination

We are pleased that H.R. 2270 has provided Medicaid beneficiaries with protection from discrimination by nursing home facilities on the basis of their ability to pay in the areas of bed-holds and readmissions. However, we are concerned that the bill does not address discrimination regarding initial admissions policies. Without any standardization of admission policies regarding "self-paying" versus Medicaid-sponsored beneficiaries, nursing homes will continue to favor those individuals who can afford to pay more for these same services over those who must rely upon public financing of their care. Such inequitable policies promote unacceptable discrimination policies.

We urge the committee to consider the provisions of H.R. 159, introduced by Representative Gallo (R-NJ), which would rectify this problem. H.R. 159 simply requires that nursing homes make available within each facility at least the average portion of beds available in the entire state to Medicaid patients. It is our understanding that this policy, currently in effect in the state of New Jersey, has had a positive effect on access to nursing home care, and has lessened the time Medicaid beneficiaries must wait for an available bed. Congress must address the issue of equitable access to nursing home facilities regardless of method of payment in order to make any nursing home reform bill meaningful.

## Conclusion

In summary, Mr. Chairman, we believe that H.R. 2270 represents an excellent starting point for the deliberations on nursing home reform. In our view, passage of many of the provisions in this legislation would improve the quality of life of nursing home residents.

However, we do not think H.R. 2270 is enough. We base our views on the experience and expertise gained from being both the major care givers, and professional employees, of nursing homes. If we are to have true reform, staffing must be improved. We cannot support legislation that continues to subject residents to no registered nurses on duty two-thirds of the time. This does not represent good quality care. Therefore, we ask that the bill be amended to provide a minimum of one RN at all times in nursing homes.

We appreciate your consideration of our views.

Mr. **Waxman**. Thank you, Ms. Harrington.
Ms. Isferding.

## STATEMENT OF HELEN ISFERDING

Ms. **Isferding**. Good morning. My name is Helen Isferding and I speak on behalf of 1.2 million members of the American Federation of State, County and Municipal Employees, 300,000 of whom work in health care facilities including 60,000 in nursing homes.

I, myself, have worked approximately 15 years providing direct care as a nurses aide and a certified occupational therapist at Lakeland Nursing Home, which is owned and operated by Walworth County, WI and am currently a staff representative servicing 5 county nursing homes.

County nursing homes in Wisconsin have a long and proud tradition of providing high quality care for the State's needy and most seriously ill. We in Wisconsin welcome the report of the Institute of Medicine. We believe reform is overdue. It is our belief that H.R. 2270 will help remedy many of the recurrent problems.

Let me now turn to several specific issues which greatly affect the provision of quality treatment for patients in nursing homes. Too often in the hectic under staffed pace of nursing home life, the rights of the residents are forgotten in order to maximize the efficiency of the overall operation.

The AFSCME Local, of which I was president, successfully lobbied our State legislature to enact the Wisconsin Nursing Home Residents Bill of Rights. We applaud the fact that H.R. 2270 will give all nursing home residents these rights.

We are equally concerned about Medicaid discrimination. Because of their open door admission policies, county nursing homes in Wisconsin in effect specialized in caring for Medicaid residents, with 10 percent more Medicaid funded residents than private nursing homes. The staff of county homes repeatedly hear stories about how Medicaid funded residents, particularly the hard to care for residents, have been turned away by private homes. It is about time all homes are required to treat these needy respectfully.

It is equally important to have additional surveys triggered by changes in ownership, in a management company, administrators or directors of nursing or by repeated deficiencies or complaints.

A major problem facing our public nursing home is privatization. In Wisconsin, counties have sold or leased at least three homes this last year. Some of our members have continued to work at these homes despite ensuing wage cuts averaging 25 percent. These members report significant changes in conditions after private takeover. A major complaint is high staff turnover and staffing shortages.

Many of the proposed changes would require additional funding. Without Federal direction, State reimbursement formulas may provide reimbursement for many of these measures because new services will push costs above a State mandated cap. County nursing homes in Wisconsin are in danger of going out of business because a significant percentage of their costs are not recognized by the State.

Private nursing homes' shortfalls shift from low Medicaid rates to private paying patients and limit access of Medicaid funded residents. Public homes do not have this option. Under Medicare, Congress has recognized the need for special reimbursement provisions for hospitals serving a disproportionate share of the poor. Likewise, it's time for Congress to begin considering the special financial needs for nursing homes serving a disproportionate share of Medicaid beneficiaries.

Our union highly supports mandatory training for all nursing home aides. We believe that trained, experienced staff is the most important factor necessary for the provision of quality care. We are also acutely aware that mandatory training and certification can be used as a method of harassment by a nursing home administrator or an owner determined to eliminate union activists or patient care whistle blowers.

Because of the potential for discrimination, we believe training should be conducted by an independent body and workers should be allowed to take the training course at least twice if the course is not initially completed.

The last issue we wish to discuss is that of resident review of mentally ill and mentally retarded individuals. It is crucially important that decisions about appropriate services be based on realistic analysis of the most appropriate setting for that individual and not on a preconceived notion about absolute superiority of noninstitutional settings.

It is reassuring that the latest draft of H.R. 2270 recognizes this reality and requires States to consider all options. I would like to commend you for recognizing the right of long-term residents to remain at the same facility is more important than moving them because they do not require the level of services in a nursing facility.

I greatly appreciate this opportunity to outline our membership's support for nursing home reform measures and I thank you.

[Testimony resumes on p. 396.]

[The prepared statement of Ms. Isferding follows:]

## TESTIMONY OF

## AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

Good Morning, my name is Helen Isferding and I speak on behalf of 1.2 million members of the American Federation of State, County and Municipal Employees; 300,000 of whom work in health care facilities, including 60,000 in nursing homes. I myself began my health care career working as a nurse aide at Lakeland Nursing Home, which is owned and operated by Walworth County, Wisconsin.

After working 5 years as an nurse aide, I became an occupational therapist and continued at the nursing home as a therapist for four years. During that period, I also worked in acute and psychiatric settings.

I served as President of our AFSCME Local at Lakeland. Since 1979, I have served as an AFSCME, Council 40 staff member servicing numerous health care facilities including nursing homes. I am currently responsible for representing AFSCME members at five county nursing homes.

County nursing homes in Wisconsin have a long and proud tradition of providing high quality care for the state's most seriously ill. In addition, because County officials are accountable for the quality of care provided, these homes are often chosen by county residents over private facilities as the best place for their loved family members to live out their lives in dignity. My uncle currently resides at Lakeland Home, where I used to work.

I have witnessed firsthand many of the problems addressed by the Nursing Home Reform Act of 1987. Before I underscore the value of individual reform measures, I wish first to acknowledge the work of the coalition of health care consumers, providers, professional groups and workers which has labored for almost one year to create a consensus for reform legislation. Rarely in the history of legislative efforts have interest groups developed public policy consensus positions to the degree achieved by the Campaign for Quality Care in Nursing Homes. In many instances, organizations made considerable compromises in order to promote overall quality resident care. We fully support the majority of Campaign consensus papers and where we disagree, we have attempted to provide alternative proposals which we believe would best meet the needs of workers and residents.

We, in Wisconsin, welcomed the report of the Institute of Medicine (IOM) last year confirming trends we have witnessed for years. As the demand for nursing home service has increased in the past decade, the overall quality of resident care has deteriorated. The quest by investor-owned nursing home chains to purchase more and more homes has forced homes to compete for private pay patients and has produced unequal treatment for many Medicaid residents further complicating the delivery of uniform quality care. Both private and public sector homes have been affected. We believe reform is overdue. Furthermore, it is our belief that the Nursing Home Reform Act of 1987 (NHRA) will help remedy many of the recurrent problems.

Let me now turn to several specific issues which qrealy affect the provision of quality treatment to Medicaid patints in nursing homes.

Too often in the hectic, understaffed pace of nursinghome life the rights of residents are forgotten in order to maxmize the efficiency of the overall operation. Residents may sit for hours in wheelchairs in hallways or in their rooms when their more severely afflicted neighbors are treated for incontinence or decubitus ulcers. My comments in this area are not intended to critize nursing home management or staff, I simply wish to emphasize the need for grievance procedures or some form of complaint mechanism which residents and their guardians may utilize to remedy inadequate care. The AFSCME Local of which I was president successfully lobbied our state legislators to enact the Wisconsin Nursing Home Residents Bill of Rights. We aplaud the fact tha the NHRA will give all nursing home residents these rights.

Residents have a right to guaranteed access and to prohibitions against arbitrary transfers. Reasonable access for relatives and agencies which provide social or legal support services must be permitted to allow further oversight of treatment. Currently, homes may transfer residents if relatives complain about treatment, if the resident criticizes the delivery of care, or for any number of other discriminatory reasons. The reform bill specifies a number of prohibitions against arbitrary transfers but we believe the right to appeal a transfer must be made to an independent, impartial representative and not merely to the State. Arbitrary transfer may lead to transfer trauma and death. To prevent such situations, residents should be notified of a potential transfer, at least 30 days prior to any transfer.

As a union we are equally concerned about Medicaid discrimination. We are all aware of blatant forms of discrimination like Medicaid segregation. In many instances, the discriminatory behavior is more subtle yet no less pervasive. For example, Medicaid recipients may not be allowed to shower as often as other residents. In fact, Medicaid recipients without immediate relatives to oversee their care may receive very perfunctory service: infrequent oral hygiene, physical therapy, or contact with the outside world.

Because of their open door admissions policies, County nursing homes in Wisconsin in effect specialize in caring for Medicaid residents. County home resident populations average 10% more Medicaid-funded residents than private homes. The staff at County homes repeatedly hear stories about how Medicaid-funded residents, particularly the hard-to-care-for residents, have been turned away by private homes. It is about time all homes are required to treat the needy respectfully.

In a number of instances, nursing home operators have required that Medicaid rights be waived. We condemn that practice. The reform bill contains strong prohibitions against such requirements. We hope Congress is committed to enacting these strong restrictions. Residents should be able to take full advantage of Medicaid benefits and should be fully informed as to their right to apply for and use such benefits. Similarly nursing homes should be prevented from requiring "responsible party" signatories as a condition of admission or continued stay in the facility.

We are also encouraged by the support for changing both the survey and certification process and the enforcement of nursing home laws and regulations. The Campaign for Quality Care consensus position outlines the major issues which must be addressed regarding the overhaul of the survey and inspection process. Based on my own experience, let me underline the importance of several of these measures.

Surveys must be unannounced and should not necessarily be within a designated 12 month period. Nursing homes too often are aware of impending inspections and prepare accordingly. Workers must work additional hours during these periods to complete the charade. Unfortunately, any changes are typically short term in nature and do not significantly affect the delivery of resident care.

It is equally important to have additional surveys triggered by changes in ownership, management company, administrator or director of nursing or by repeat deficiencies or complaints. Assessment of care must include interviews and observations of residents and staff members and must focus upon resident care instead of only quantifiable measures.

A major problem faced by our public nursing homes is privatization, whereby operation of the homes is turned over to a private bidder. In Wisconsin, counties have sold or leased three homes in the last year. Some of our members have continued to work at those homes, despite ensuing wage cuts averaging 25%. These members report significant changes in conditions after private takeover. A major complaint is high staff turnover and staffing shortages.

To ensure quality care, survey changes must be coupled with a range of enforcement actions. In the past, rigid remedies were not imposed because the loss of Medicaid funding would jeopardize resident care. For several years, nursing home advocates have been lobbying for the development of an array of enforcement actions which could be tailored to fit the deficiency. We believe reforms in this area could have the most profound affect on nursing home administrator behavior and ultimately on the delivery of care. States should devise a range of actions to respond to the severity and frequency of deficiencies. Chronic or repeat offenders of licensure or certification regulations must face severe penalities to deter their actions. While the NHRA contains intermediate sanction provisions, we believe the Act should contain additional language outlining remedies for repeat offenders and for specific serious deficiencies.

We regret that an earlier provision prohibiting conflicts of interest among nursing home regulations has been dropped. We urge that this problem be addressed.

All of the NHRA provisions must be viewed within a funding context. Many of the proposed changes will require additional funding. State reimbursement formulas may prevent reimbursement for many of these measures because new services will push costs above a state mandated cap. We believe Congress should carefully design funding mechanisms which allow reasonable reimbursement for desirable reform measures.

County nursing homes in Wisconsin are in danger of going out of business because a significant percentage of their costs are not recognized by the state reimbursement system. These homes have higher costs because they treat more difficult patients and because they pay better wages and benefits, to retain experienced staff. Private homes shift shortfalls from low Medicaid rates to private paying patients, and limit access of Medicaid-funded residents. Public homes do not have this option. Under Medicare, Congress has recognized the need for special reimbursement provisions for hospitals serving a disproportionate share of the poor. Likewise, it is time for Congress to begin considering the special financial needs for nursing homes serving a disproportionate share of Medicaid beneficiaries. AFSCME and senior citizen advocacy organizations are working on a project that will define the characteristics and needs of "disproportionate share" nursing homes. We will be providing this Committee with our results.

The foregoing issues have received widespread attention and discussion. The consensus positions developed by the organizations participating in the Campaign for Quality Care in Nursing Homes represent genuine reform measures. While we heartily endorse all but two of those consensus positions, we do believe several additional changes are necessary to promote quality nursing home care.

Our union wholeheartedly supports mandatory training for all nursing home nurse aides. We believe trained, experienced staff is the most important factor necessary for the provision of quality care. Any legislation, though, must insure that training programs are realistically related to the acutal duties performed by the affected individuals.

We are also acutely aware that mandatory training and certification can be used as a method of harassment by a recalcitrant nursing home administrator or owner determined to eliminate union activists or patient care whistle-blowers. Only a handful of states have mandated state-wide training and certification and the majority of these states have excused existing staff from required completion of this training. The rational for this approach is that unnecessary job loss could result from inequitable administration of testing.

At a minimum, because of the potential for discrimination, we believe training should be conducted by an independent body and workers should be allowed to take the training course at least twice if the course is not initially completed. We propose that States guarantee that the training is fairly and objectively administered and graded by persons or organizations who have no conflict of interest or vested interest in the outcome of the training. This measure would not only promote the development of trained staff but would also eliminate blatant forms of worker discrimination. In addition, costs for the training must be Medicaid reimbursed in such a manner, utilizing a pass-through system, that despite Medicaid caps, homes are adequately reimbursed. Otherwise, low-paid aides will have to bear the cost of training.

The submitted reform legislation calls for the assessment of a resident's needs. Such assessments will be accurate only if there is input from current caregivers, especially personal physicians, facility healthcare professionals, direct care staff and family members. In many instances, direct care staff have years of experience caring for specific patients. These individuals have an excellent understanding of the treatment needs of nursing home residents.

The last issue we wish to discuss is that of resident review of mentally ill and mentally retarded individuals. It is crucially important that decisions about appropriate services be based on a realistic analysis of the most appropriate setting for that individual and not on preconceived notions about the absolute superiority of noninstitutional settings. It is reassuring that the latest draft of the NHRA recognizes this reality and requires states to consider all options. Before any transfer takes place, residents should be guaranteed a specific placement that will better meet their needs. We would like to commend the authors of the NHRA for recognizing that guaranteeing long term residents the right to remain at the same facility is more important than moving residents because they do not require the level of services in the nursing facility.

Furthermore, residents must have direct input into any transfer decision. Such input includes a timely appeals process open to residents, relatives, guardians, caregivers or advocates. The procedures for the appeals process should include an impartial hearing officer.

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I greatly appreciate the opportunity to outline our membership's support for nursing home reform measures. Nursing home residents cannot always advocate for themselves. When they are able, oftentimes their access to ombudspersons or advocates is blocked. Despite low wages and long hours, our members have worked to deliver quality care and to actively advocate on behalf of residents. Our members know working conditions and patient care cannot be separated. Attention to one area creates quality in the other.

Many of the reforms our members seek are included in the Nursing Home Reform Act of 1987. Improved staffing and mandatory training will encourage individualized treatment, while measures designed to prevent Medicaid discrimination and to strengthen the survey and enforcement process will also induce a greater emphasis on meeting the needs of nursing home residents.

I also wish to commend the efforts of the National Citizen's Coalition of Nursing Home Reform in their role of creating a dynamic, effective consumer, provider, and worker coalition dedicated to a campaign for quality care in nursing homes. The recommendations of that coalition if enacted will remedy many of the more flagrant deficiencies found in the nursing home regulatory system. The Reform Act will not solve all problems for nursing home residents or workers, but it will set a new significantly higher standard of quality. We intend to work actively towards that goal.

Thank you.

Mr. **Waxman**. Thank you very much for that testimony.

Mr. Sweeney and Ms. Isferding, both of you have talked about the need for strong enforcement mechanisms as part of any nursing home reform package that Congress may enact.

From the perspective of nursing home employees, those that actually provide the care, why are such provisions necessary? Do you believe States are doing an adequate job in enforcing current nursing home rules and regulations? Do you believe that enforcement provisions in H.R. 2270 are appropriate or are even tougher sanctions needed?

Mr. **Sweeney**. I think that H.R. 2270, the enforcement provisions in the bill, are excellent. I think there are a number of examples of States where the enforcement practices are not effective and I believe there should be national enforcement standards. The workers in the nursing homes are most concerned about patient care and about the best provisions for the patients they are caring for, and the only way it can be effective is through strong enforcement.

Mr. **Waxman**. What do you think? Are the States doing an adequate job?

Ms. **Isferding**. From my experience in working with a nursing home, you have heard people testify, yes, people knew they were coming. Let me assure you, we did know when those people were coming from the State. For instance, I could walk on a ward and could tell by the number of staff that was there that we were expecting a nursing home surveyor that day. The preparation for those types of State surveys would happen maybe a week to a week and a half. You would see charting getting done. You would see things happen in the cleaning areas and you would see the schedules that would be upon the board change and the staff increased.

Yes; I think they are needed.

Mr. **Waxman**. Thank you very much.

Dr. Harrington, I know how important the staffing issue is to the Nurses Association. I know that you strongly support the 24-hour registered nursing requirement for all facilities that was included in the legislation we introduced last Congress.

Let me say from the outset that I was reluctant to make changes in that requirement. Two factors, however, persuaded me that some modifications were needed at this time. First is the cost of implementing a 24-hour requirement. Second, a point that you have acknowledged in your testimony today, is that there is in fact insufficient registered nurse staff to respond to the increasing intensity of patient care needs.

If this is true, how could facilities hope to meet the 24-hour registered nursing requirement in the next 3 to 5 years?

Ms. **Harrington**. The key question here is one of salary. At the present time, nursing homes pay generally on average about 15 percent below the hospital average payment rates. We feel that nursing homes have historically paid lower salaries for all levels of nursing personnel and this is an artificial decision on their part. This has created the problem of not being able to have adequate personnel within nursing homes.

We would like to see the wages made competitive with other health care workers. We feel that would go a long way to attracting the kinds of personnel that we need to have in nursing homes.

We know there would be a cost to this proposal that we are making, but we feel that a $20 million cost, when in the country we are spending $36 billion on nursing homes, this is minimal. Many good nursing homes already have adequate nurses on staff and many States have these requirements at certain levels. This is not going to force all nursing homes in the country to increase staff, but it will force those nursing homes that don't now have adequate staff to bring those up to minimum standards.

Mr. **Waxman**. Thank you very much for that answer.

Mr. Walgren.

Mr. **Walgren**. Thank you, Mr. Chairman.

I wonder if there is more we can say about the benefit of the 24-hour presence? Instinctively, I think we assume it, as you said in your testimony, Dr. Harrington, that people are in nursing homes because they need nursing. That implies I think the presence of a recognized professional level. I think people want it to be there.

Are there other ways we can demonstrate the benefit of the presence of the registered nurse for the other two-thirds of the day?

Ms. **Harrington**. We know you need nursing care 24 hours a day in nursing homes. It isn't just on the day shift. We can give you a number of examples of very serious problems that have happened. On average, the current staffing level requires only one nurse per 100 patients, which is about 12.5 minutes of registered nursing care a day.

An example recently in our area, in Northern California, at a well known chain facility, there was a patient who was a double amputee, who was blind and deaf. She was admitted to the nursing home. They put the patient in bed and pulled up the side rails and left her unattended. She turned over, got caught between the bed and the side rail with her face down on the pillow and suffocated. This was definitely a result of not having adequate staffing and not having professional staffing who would understand this patient was vulnerable to turning over and having this problem occur.

We could give you many examples. Another recent example of a 72-bed facility in our Sate, an inspection found that 24 percent of the patients were bruised and had skin pares, a number of them also had decubitus ulcers. Again, this was a direct result of not having adequate staffing, not having professional staffing that supervised the aides that were working with these patients.

When you have 100 or 50 patients at night to supervise, you can't do it as a nurse.

Mr. **Walgren**. It's hard to imagine what you can do for somebody in 12 minutes.

Ms. **Harrington**. It's very hard. Mostly what the registered nursing staff do is general supervision and they may supervise the medications and make sure everything looks like it is in order.

Mr. **Walgren**. The role of the registered nurse in the nursing home now is largely supervisory and response oriented, I gather, if there is an incident or some kind of very immediate need.

Ms. **Harrington**. That's right. We know we need nurses to do the assessments of patients. It is estimated that 30 percent or more of the patients in nursing homes have decubitus ulcers; over 50 percent have incontinence; some of them have malnutrition, all kinds of problems that really require a registered nurse to assess that patient, develop a plan of treatment and supervise the care. This isn't happening because we basically don't have enough nurses and enough nursing assistants.

Mr. **Walgren**. Although their time might best be used in a supervisory and evaluating way, is that happening in the nursing homes now or they put essentially on the front line to administer the care?

Ms. **Harrington**. That's exactly what we are saying, it's not happening because we don't have enough nurses for the patients. We need more registered nurses to carry out all aspects of the supervision of patient care, the inservice education. Nursing care in these nursing homes at this present time is very complex. We are seeing patients on respirators with I.V. medications. Some of them have 6 to 14 different medications that have to be administered.

If you do not have professional nursing staff, you are going to have problems, and that's exactly what we have today in many homes.

Mr. **Walgren**. I want to underscore that 12 minutes a day. I don't know how that is a comfortable position for any nurse.

Thank you, Mr. Chairman.

Mr. **Waxman**. Thank you very much, Mr. Walgren. Thank you for your testimony today. We appreciate your being here. We look forward to working with you.

We are now going to recess until 2 o'clock and then we will reconvene in this room.

[Whereupon, at 12:45 p.m., the subcommittee recessed, to reconvene at 2 o'clock p.m. this same day.]

### AFTER RECESS

Mr. **Waxman**. The meeting of the subcommittee will come back to order.

Our next witness is here today on behalf of the administration. Mr. Louis B. Hays is Associate Administrator for Operations with the Health Care Financing Administration, the Federal Agency that has final responsibility for regulating the 14,000 nursing homes participating in the Medicaid program.

Thank you, Mr. Hays, for being with us this afternoon. Your prepared statement, of course, will be part of the record. We would like to ask you, if you would, to summarize that statement in no more than 5 minutes.

## STATEMENT OF LOUIS B. HAYS, ASSOCIATE ADMINISTRATOR FOR OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. **Hays**. Thank you, Mr. Chairman.

I am accompanied this afternoon by Mr. Tom Morford, the Director of our Bureau of Health Standards and Quality, the part of our organization that has the direct responsibility for survey and certification of facilities participating in Medicaid and Medicare.

I welcome the opportunity to be here this afternoon. Let me begin by reaffirming that there is nothing more important to Secretary Bowen and Dr. Roper, our administrator, than assuring that the poor, elderly, sick and disabled receive quality health care in whatever setting appropriate.

H.R. 2270 would, with a great deal of specificity, revise the conditions of participation and the process for surveying nursing homes. Most of what is included in the bill can be accomplished without statutory changes, but rather through the Secretary's existing authority to promulgate regulations. We plan a rulemaking process consistent with the Administrative Procedure Act, which requires the opportunity for public comment.

We want to offer a generous period of time for all involved—providers, State agencies, advocacy groups, nursing home residents—to comment. Then we will respond to all comments in a final rule. We, hope the committee would await the results of this process before undertaking further statutory changes.

My prepared statement, of course, includes additional comments on H.R. 2270, but now I would like to take an opportunity to describe some of our activities to improve the quality of care in nursing homes and to implement the recommendations of the Institute of Medicine.

Our approach has two principles. First, quality can be improved by focusing our regulatory processes on outcomes of care. Second, quality can be improved by identifying the poorest performers and either ensuring that they improve or terminating their participation in Medicare and Medicaid.

Last July, we implemented the new Long-term Care Survey Process, a milestone in turning our regulatory focus toward resident outcomes. This new process focuses the surveyors' efforts on resident care. Surveyors now spend more of their time in direct observation of residents, their conditions, their care, services and treatments, in addition to the general condition of the facility.

We have also strengthened our procedures to terminate facilities that no longer meet Federal requirements, particularly if the condition poses an immediate and serious threat to the health and safety of residents. In fiscal year 1986, 73 nursing homes were terminated from Medicare and Medicaid. Another 166 nursing homes voluntarily withdrew from participating in the programs, including many who did so to avoid being terminated.

All of these efforts have contributed to an improvement in the care received by nursing home residents, and we continue to do the additional work that we recognize needs to be done.

The Institute of Medicine stressed the need to make major revisions to the nursing home requirements and to our monitoring and enforcement rules. We are now developing detailed statutory, regulatory and administrative proposals. Some of the most important parts of the rules include the following:

—Revised nursing home conditions of participation, which will include provisions on residents' rights, resident assessment, quality of care and quality of life. These revised conditions of participation will focus on positive outcomes of care to be achieved and negative outcomes to be avoided;

—A flexible survey cycle, which will vary depending upon the performance of the providers;

—Stronger rules prohibiting certification of facilities which year after year go in and out of compliance;

—Finally, specific time frames a facility must wait to reenter the program after having been terminated from participation. These last two provisions will have a forceful impact on quality by ending participation of marginal facilities.

We do agree that some of the Institute of Medicine recommendations cannot be accomplished without legislative changes, and we are now developing a number of legislative proposals. We would combine the survey and certification and inspection of care systems. In many States, these are two separate activities that often conflict with each other, and as in your bill, the Department would certify publicly operated facilities for participation in Medicaid to eliminate the inherent conflict of interest.

We would also penalize States that do not follow procedures for conducting inspections of care as well as the survey process, and in those States where we find that surveyors lack the necessary expertise, we would require the surveyors to meet Federal standards.

In closing, let me emphasize that we are committed to careful and orderly changes in the regulation of nursing homes. We recognize that both defining and assuring quality only can be accomplished through a cooperative spirit among Congress, the administration, the providers and consumers. We believe that together, we can make the appropriate improvements in our quality assurance system.

I can assure you of the administration's commitment to do the very best possible job to reach our shared objectives.

Now, Mr. Chairman, Mr. Morford and I would be pleased to answer any questions you might have.

[The prepared statement of Mr. Hays follows:]

## STATEMENT OF LOUIS B. HAYS

I welcome the opportunity to be here this morning to share our views on the "Medicaid Nursing Home Quality Amendments of 1987." Let me begin by reaffirming that there is nothing more important to Secretary Bowen and the Health Care Financing Administration than assuring that the poor, elderly, sick, and disabled receive quality health care. Much of you bill overlaps the Department's initiatives relating to quality care provided to Medicare and Medicaid beneficiaries in nursing homes, so I want to discuss our current activity in this area and the Department's plans for future action.

H.R. 2270 would, with a great deal of specificity, revise the conditions of participation for nursing homes in the Medicaid program, revise the process for surveying facilities to assure their compliance with those conditions, and require States to take action against facilities which do not comply with the conditions. These are preliminary comments. Once we have had an opportunity to more thoroughly review the bill we would be happy to provide additional comments.

Most of what is included in the bill can be accomplished without statutory changes but through the Secretary's authority to promulgate regulations beyond those already included in statute. We plan a rulemaking process, consistent with the Administrative Procedures Act which requires the opportunity for public comment.

We want to offer a generous period of time for all involved—providers, State agencies, advocacy groups, nursing home residents—to comment. Then we will respond to all comments in a final rule. We hope you will await the results of this process before undertaking statutory changes.

1. The bill proposes to eliminate any differential in standards and reimbursement between skilled nursing facilities and intermediate care facilities. Although we realize that these distinctions may not be always clear, we oppose eliminating these distinctions. The impact on recipients, as well as the cost and coverage implications must first be known. If States view all facilities as the same and pay the same for all care, this proposal is likely to produce the unintended result of creating access problems for individuals with high care needs or significantly increasing State and Federal costs, while providing no medical benefit for the recipient. In addition, a

number of States are currently experimenting with case mix reimbursement systems, and we believe the results of these experiments should be studied.

2. The bill would require States to have to wide range of sanctions as alternatives to decertification. We believe that States should have flexibility to structure their own sanctions. Many States have already implemented a variety of sanctions including fines, receiverships, escrow accounts, monitors and restrictions on admissions.

3. We agree with the objective of the bill to limit survey costs but we see no reason to delay such action until 1993 as the bill would do. We strongly object to increasing the matching rate for State survey and certification activity. We believe that States should be equally committed to quality of care, and that States should share equally in the costs of surveying facilities that participate in Medicaid. We currently pay 75 percent of those costs. The original purpose of the enhanced payment was to help States develop strong and viable survey agencies. This goal has long since been realized.

4. We strongly endorse the provision in your bill to allow financial penalties to be taken against States which have been deficient in meeting their survey responsibilities. We believe this will provide incentives for States to conduct survey activates in concert with Federal requirements.

Having addressed the provisions of H.R. 2270 which most concern us, I would now like to describe some of our activities to improve the quality of care in nursing homes and to implement recommendations of the institute of medicine.

Our approach has two principles. First, quality can be improved by focusing our regulatory process on outcomes of care. Second, quality can be improved by identifying the poorest performers and either ensuring they improve or terminating their participation in the Medicare and Medicaid program.

Last July we implemented the new long-term survey process, a milestone in turning our regulatory focus towards resident outcomes. This new process focuses a surveyor's efforts on resident care. Previously, not enough time was spent talking to the residents and assessing their condition. The new approach has changed that. Now surveyors spend more of their time in direct observation of residents—their condition, their care, services, and treatments, as well as the general condition of the facility. To acquire an accurate assessment of resident care, they conduct in-depth interviews with about 20 percent of the residents.

We have also strengthened our procedures to terminate facilities that no longer meet Federal requirements, particularly if the condition poses an immediate and serious threat to the health and safety of residents. In fiscal year 1986, 73 nursing homes were terminated from Medicare and Medicaid. Another 166 nursing homes voluntarily withdrew from participating in the programs, including many who did so to avoid being terminated.

We have increased our budget for Medicare and Medicaid long-term care surveys. In fiscal year 1985, total State and Federal spending for survey and certification was $102 million. Of this amount, the Federal Government spent $89 million while the States spent $13 million. Fifty-eight million of the Federal dollars went specifically for survey for certification of nursing homes. For fiscal year 1988, total State and Federal spending is expected to be $141 million for survey and certification activities. The President has required $123 million while the States are expected to spend $18 million. Eighty three million of the Federal dollars will be devoted to nursing homes. This means that since fiscal year 1985, we have almost doubled our nursing home survey budget.

We have a number of demonstration projects that are looking at ways to improve quality of care in nursing homes. The recommendations of the Institute of Medicine reflect the results of some of our earlier demonstrations, particularly those allowing States to utilize screening techniques to determine which nursing homes are likely to have the most deficiencies.

All of these efforts have contributed to an improvement in the care received by nursing home residents. And, we continue to do the additional work that we recognize needs to be done.

The Institute of Medicine stressed the need to make major revisions to the nursing home requirements and to our monitoring and enforcement rules. We are now developing detailed statutory, regulatory and administrative proposals.

Some of the most important parts of the rules we are developing include:

—Revised nursing home conditions of participation which will include provisions of residents' rights, resident assessment, quality of care and quality of life. These revised conditions of participation will focus on positive outcomes of care to be achieved and negative outcomes to be avoided.

—A flexible survey cycle which will vary depending on the performance of the provider,

—Stronger rules prohibiting certification of facilities which year after year go in and out of compliance, and

—Specific time frames a facility must wait to reenter the program after having been terminated from participation.

These last two provisions will have a quick and forceful impact on quality by ending the participation on marginal facilities. We do agree that some of the IOM recommendations cannot be accomplished without legislative changes, and we are now developing a number of legislative proposals.

We would combine the survey and certification and inspection of care systems. In may States these are two separate activities that often conflict with each other. As in your bill, the department would certify publicly-operated facilities for participation in Medicaid to eliminate the inherent conflict of interest.

We would penalize States that do not follow procedures for conducting inspections of care as well as the survey process. And in those States where we find that surveyors lack the necessary expertise, we would require the surveyors in those States to meet Federal standards.

In closing, let me emphasize, we are committed to careful and orderly changes in the regulation of nursing homes. We recognize that both defining and assuring quality only can be accomplished through a cooperative spirit among Congress, the administration, the providers and consumers. We believe that together we can make the appropriate improvements in our quality assurance system. I can assure you of the administration's commitment to do the very best possible job to reach our shared objectives.

I would be glad to answer any questions you may have.

Mr. WAXMAN. Thank you very much for your testimony.

What strikes me about your statement is that it sounds like we are trying to achieve the same objectives and yet you still can't support this legislation. You want to focus the regulatory process on outcomes of care and so does the bill. You want to identify the poor performers and either get them to improve or terminate their participation in Medicaid, and so does this bill. Yet you oppose the bill, evidently, I think, because it will cost the Federal Government some money.

How do you propose to improve the quality of care in nursing homes without investing any additional Federal spending?

Mr. HAYS. First, Mr. Chairman, I would suggest that any opposition to the bill at hand is not based solely on financial analysis of that bill. I think we have a broader concern that addresses the question of the specificity of requirements that should be imposed through legislation as opposed to administrative action. We are concerned about having specific mandates locked into the statute which may prove, upon experience, to be less than fully desirable. We would prefer the flexibility of the regulatory and administrative approach.

Ironically, I think it is conceivable that by going the legislative route, as opposed to the administrative route, there could, in fact, be the potential for further delay because undoubtedly any piece of legislation will in turn require some degree of regulatory implementation.

Mr. WAXMAN. If we wait for regulatory implementation of some of these ideas, do you have any indication from OMB that they are going to clear a final rule for publication or that they are even going to clear a proposed rule? Don't you think there is a possibility that your timetable will slip as OMB might be blocking your actions? So not only will you not have flexibility, you won't be able to do what you want to do by regulation.

Mr. HAYS. I have no reason to believe, Mr. Chairman, that our proposals will be blocked at OMB.

Mr. WAXMAN. Have you consulted with OMB about your proposals?

Mr. HAYS. In a general way, not in full specificity but in a general way we have.

Mr. WAXMAN. And in a general way they are supportive; is that a correct statement?

Mr. HAYS. I have no indication that they are going to oppose our proposal.

Mr. WAXMAN. Do you have any indication they are going to support your proposal?

Mr. HAYS. I have every hope that they will support and, more importantly, approve for publication our proposed regulation.

Mr. WAXMAN. Well, I think if you want to get some of these ideas into law, you have a better chance with the Congress, but we will work together on it.

Thank you very much for your testimony.

The members of our next panel represent various agencies at the State level that are involved in the regulation of nursing homes participating in Medicaid. Mr. Aaron J. Johnson is both Chairman of the State Medicaid Directors Association and Commissioner of the Georgia Department of Medical Assistance. He is testifying today on behalf of the American Public Welfare Association.

Ms. Mary Marshall is a delegate with the State of Virginia and serves as Chair of the Task Force on Long-term Care for the Elderly with the National Conference of State Legislatures. Ms. Ileana Saros is Director of the New Jersey Medicaid Fraud Control Unit and President of the National Association of Medicaid Fraud Control Units.

I want to thank you for appearing before our subcommittee today. Of course, your prepared statements are going to be part of the record. We would like to ask you to stick very closely to the 5-minute presentation.

Why don't we start with Mr. Johnson.

## STATEMENTS OF AARON J. JOHNSON, CHAIRMAN, STATE MEDICAID DIRECTORS' ASSOCIATION, COMMISSIONER, GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE, AND ON BEHALF OF AMERICAN PUBLIC WELFARE ASSOCIATION; MARY A. MARSHALL, ON BEHALF OF, NATIONAL CONFERENCE OF STATE LEGISLATURES; AND ILEANA N. SAROS, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Mr. JOHNSON. Good afternoon, Mr. Chairman.

As you just introduced me, I am Aaron Johnson, commissioner of the Georgia Department of Medical Assistance and chairman of the State Medicaid Directors Association, which is affiliated with the American Public Welfare Association.

I have come today to present the views of the State Medicaid agencies on the Medicaid Nursing Facility Quality Care Amendments of 1987. Although our association has not had a chance to meet and adopt an official position on the bill, I can present to you the impressions of the State Medicaid directors regarding its various provisions, particularly since it closely mirrors last year's bill and follows the recommendations of the insightful Institute of Medicine study improving the quality of care in nursing homes.

First, Mr. Chairman, I would like to compliment you and Chairman Dingell on the bill you have produced on such a complex topic. As the directors of State Medicaid programs, we hold unique positions as financers and regulators of nursing homes, and we understand what a difficult issue providing quality care can be. I hope our views will benefit your deliberations.

While I have submitted more detailed testimony regarding the State Medicaid Directors views of the IOM study, let me focus on a few key issues.

We agree with the general thrust of this legislation in focusing on patient needs and care actually provided rather than evaluating a nursing home's capability to provide care. As payers of these services, we are far more concerned with outcome than with process. A refocusing of the conditions of participation toward patient care and away from the facilities' physical plant and the current paperwork requirements will greatly enhance the ability of the review process to assure quality care.

The States believe that the recommendations in H.R. 2270 regarding the monitoring of nursing home performance will lead to a more efficient and effective use of the limited resources available. We believe the current system contains a great deal of waste. In particular, we support the use of a standard surveying instrument with a sampling of patient assessments for most homes.

Resources should be focused on the problem facilities by using extended surveys when problems are identified through the standard survey. In the past, requirements of 100 percent reviews have led to unnecessary penalties to States without any proof that these reviews or penalties benefit nursing home residents.

One of the more controversial recommendations is to do away with any distinction between skilled nursing facilities and intermediate care facilities. While the State Medicaid Directors agree that such a distinction is often hard to differentiate between facilities in different States, the proposal holds some potential problems.

The first is that because the proposed single classification would require 24-hour nursing services, the overall cost of nursing care will go up. The increase in costs should not be ignored. Second, setting a single level of care which requires 24-hour nursing could have an adverse effect on residents who require less care. Residents who only require 10 hours of licensed nursing care become ineligible for nursing home service under Medicaid.

Obviously, this is not the intent of the recommendation, but recent trends in the administration of the Medicare program have shown that meeting the level of care is a crucial factor in determining eligibility. Clarification of the intent of this recommendation is necessary should the subcommittee pursue it.

Combining the inspection of care and survey and certification process is basically a sound idea, but State Medicaid agencies do have some reservations. Because both the IOC and survey and certification process are carried out by teams with similar professional personnel at different times, combining the two processes will save the State and Federal Government funds in terms of personnel and travel, and it will reduce the paperwork requirements for the nursing facilities.

Many Medicaid directors, however, are concerned that the patient care which we, Medicaid, is paying for is going to be evaluated by a different State agency. Several States have, however, already combined their IOC and survey and certification efforts and are pleased with this approach.

We believe that the solution to our concern is contained in the bill, which would allow States to continue inspection of care activities with Federal financial participation if they choose. This will allow each State to work toward an appropriate balance of the two activities.

Mr. Chairman, I hope my comments will be of use to you and the other members of the subcommittee in your continued deliberations regarding improving the quality of care in nursing homes. The State Medicaid Directors stay ready to assist you in any way that we can.

Thank you for inviting me to testify today. I would be happy to answer any questions you might have.

[Testimony resumes on p. 417.]

[The prepared statement of Mr. Johnson follows:]

## TESTIMONY OF
## AARON J. JOHNSON

GOOD MORNING MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM AARON J. JOHNSON, COMMISSIONER OF MEDICAL ASSISTANCE FOR THE STATE OF GEORGIA. IN ADDITION, I AM CURRENTLY SERVING AS CHAIRMAN OF THE STATE MEDICAID DIRECTORS' ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION.

I HAVE COME TODAY TO PRESENT THE VIEWS OF THE STATE MEDICAID AGENCIES ON THE MEDICAID NURSING FACILITY QUALITY CARE AMENDMENTS OF 1987 (H.R. 2270). ALTHOUGH OUR ASSOCIATION HAS NOT HAD A CHANCE TO MEET AND ADOPT AN OFFICIAL POSITION ON THE BILL, I CAN PRESENT TO YOU THE IMPRESSIONS OF THE STATE MEDICAID DIRECTORS REGARDING ITS VARIOUS PROVISIONS, PARTICULARLY SINCE IT CLOSELY MIRRORS LAST YEAR'S BILL AND FOLLOWS THE RECOMMENDATIONS OF THE INSIGHTFUL INSTITUTE OF MEDICINE STUDY, IMPROVING THE QUALITY OF CARE IN NURSING HOMES.

MR. CHAIRMAN, I WOULD LIKE TO COMPLIMENT YOU AND CHAIRMAN DINGELL ON THE BILL YOU HAVE PRODUCED ON SUCH A COMPLEX TOPIC. AS THE DIRECTORS OF THE STATE MEDICAID PROGRAMS WE HOLD UNIQUE POSITIONS AS FINANCERS AND REGULATORS OF NURSING HOMES, AND WE UNDERSTAND WHAT A DIFFICULT ISSUE PROVIDING QUALITY CARE CAN BE. I HOPE OUR VIEWS WILL BENEFIT YOUR DELIBERATIONS.

I WOULD LIKE TO COMMENT ON THE BILL'S PROVISION IN THE ORDER IN WHICH THEY APPEAR.

REQUIREMENTS FOR NURSING FACILITIES (SECTION 2)

THE STATE MEDICAID AGENCIES SUPPORT ELIMINATING THE DISTINCTION BETWEEN A SKILLED NURSING FACILITY (SNF) LEVEL OF CARE AND AN INTERMEDIATE CARE FACILITY (ICF) LEVEL OF CARE, HOWEVER, THERE ARE SOME POTENTIAL PITFALLS. THE REASON FOR ELIMINATING THIS DISTINCTION AS PRESENTED IN THE IOM STUDY IS THAT THERE IS NO CLEAR DIFFERENCE BETWEEN THE LEVEL OF CARE PROVIDED TO SNF RESIDENTS IN ONE STATE AND ICF RESIDENTS IN ANOTHER. IT IS CERTAINLY TRUE THAT INCONSISTENCIES EXIST BETWEEN THE ICF CARE PROVIDED IN ONE STATE AND THE ICF CARE IN ANOTHER, JUST AS THE CARE RECEIVED BY A SNF RESIDENT IN ONE STATE IS DIFFICULT TO DIFFERENTIATE FROM THE ICF CARE IN ANOTHER STATE. WE DO HAVE TWO CONCERNS, HOWEVER, REGARDING THIS PROVISION.

FIRST, SINCE THE PROVISION IN THE BILL CALLS FOR SETTING A SINGLE LEVEL OF CARE EQUAL TO THE CURRENT SNF LEVEL REQUIRING 24-HOUR NURSING SERVICES, IT WILL SIGNIFICANTLY INCREASE THE COST OF NURSING HOME CARE PROVIDED UNDER THE MEDICAID PROGRAM. ALSO, SINCE THIS PROVISION DOES NOT RECOGNIZE THAT IN MANY STATES ICF LEVEL RESIDENTS DO NOT REQUIRE THE PRESENCE OF LICENSED NURSES 24 HOURS A DAY, THIS REQUIREMENT, PARTICULARLY GIVEN THE NATIONAL SHORTAGE OF LICENSED NURSES, WOULD CONTRIBUTE UNNECESSARILY TO THE SHORTAGE OF HEALTH CARE PROFESSIONALS ALREADY BEING EXPERIENCED. PERHAPS A REASONABLE APPROACH WOULD BE TO RELATE THE PROFESSIONAL STAFFING TO THE NEEDS OF THE PATIENT MIX BASED ON

THE RESIDENT ASSESSMENT. THIS COULD RELATE PROGRAM COSTS TO PATIENT NEEDS. AS SERVANTS OF THE PUBLIC IT IS OUR JOB TO RECOGNIZE ALL OF THE COSTS AND BENEFITS, AND WE MIGHT BE BUYING MORE THAN IS NECESSARY WITH A SINGLE LEVEL OF HIGH OPTION CARE.

SECOND, SETTING A SINGLE LEVEL OF CARE STANDARD WHICH REQUIRES 24-HOUR NURSING COULD HAVE AN ADVERSE EFFECT ON RESIDENTS WHO REQUIRE LESS CARE. THE RESIDENTS WHO ONLY REQUIRE 10-HOURS OF LICENSED NURSING SUPERVISION NOW IN ICF, ARE AS MUCH IN NEED OF 24-HOUR NURSING CARE AS THOSE REQUIRING 24-HOUR LICENSED NURSE SUPERVISION. WILL RESIDENTS WHO ONLY REQUIRE 10-HOURS OF LICENSED CARE BECOME INELIGIBLE FOR NURSING HOME SERVICES UNDER MEDICAID? I MENTION THIS IN THE CONTEXT OF CURRENT TRENDS WHERE THE ASSESSMENT OF THE LEVEL OF CARE A PERSON NEEDS HAS BECOME A CRUCIAL FACTOR IN THEIR ELIGIBILITY. THE MEDICARE PROGRAM IS THE BEST EXAMPLE. OBVIOUSLY, THE INTENT OF THE BILL IS NOT TO DENY MEDICAID COVERAGE TO PEOPLE IN NEED OF LONG-TERM INSTITUTIONAL CARE. IT IS IMPORTANT TO CLARIFY THAT THE IMPLEMENTATION OF THIS PROVISION WILL NOT RESULT IN SUCH A POLICY. WE DO NOT WANT TO GO BACK TO THE EARLY YEARS OF THE PROGRAM WHEN ONLY THE INDIVIDUALS NEEDING HIGHER CARE SNF SERVICES WERE COVERED.

OUR GOAL SHOULD BE ADEQUATE PROFESSIONAL STAFFING TO DELIVER THE CARE NEEDED BY THE RESIDENTS IN NURSING FACILITIES. THERE IS A SIGNIFICANT DIFFERENCE BETWEEN THE TYPES OF STAFFING NEEDS OF

REHABILITATION PATIENTS VERSUS RESIDENTS REQUIRING LESS CARE. WE WOULD SUGGEST A VARIABLE STAFFING REQUIREMENT BASED ON THE AMOUNT OF PROFESSIONAL STAFF NECESSARY TO PROMOTE RECOVERY AND ENHANCE THE QUALITY OF LIFE FOR EACH RESIDENT. THIS MIGHT PROVE LESS EXPENSIVE AND AVOID ANY ADVERSE IMPACT ON RESIDENTS CURRENTLY IN NEED OF ICF CARE.

WE BELIEVE THE PROPOSED REQUIREMENT FOR CONDUCTING STANDARDIZED RESIDENT ASSESSMENTS, AT REASONABLE INTERVALS, IS A GOOD IDEA. THE STATE MEDICAID AGENCIES BELIEVE THE BENEFIT FROM SUCH A PROCEDURE IS CLEAR IN TERMS OF ACCURATELY ASSESSING A PATIENT'S CONDITION OVER TIME AND CORRECTLY ASSESSING THE QUALITY OF CARE PROVIDED BY DIFFERENT NURSING FACILITIES. MORE GENERALLY, WE BELIEVE THAT THE PATIENT ASSESSMENTS ARE THE KEY ELEMENTS IN ESTABLISHING A SYSTEM THAT FOCUSES ON THE CARE ACTUALLY PROVIDED TO RESIDENTS RATHER THAN THE CARE A FACILITY IS CAPABLE OF PROVIDING.

REQUIRING THE PROVISION OF A CORE GROUP OF SERVICES AND ACTIVITIES IS ANOTHER GOOD IDEA. IN PARTICULAR, REQUIRING 24-HOUR NURSING SERVICES SUFFICIENT TO MEET THE NEEDS OF THE RESIDENTS, BUT NOT REQUIRING UNNECESSARY SERVICES FROM REGISTERED NURSES IS A REASONABLE APPROACH.

THE STATE MEDICAID AGENCIES SUPPORT THE ESTABLISHMENT OF MINIMUM REQUIREMENTS FOR NURSE AIDE TRAINING. WE BELIEVE THE PROPOSAL IS quite reasonable because it would allow such training to occur in the nursing facility. We would hope that in establishing the minimum standards the Secretary will consult with the states.

We support each of the proposed requirements relating to residents' rights. The state Medicaid directors strongly oppose any form of discrimination against an individual based on the source of payment. We applaud the distinction made in this context between "Medicaid-related" services and other services. State agencies should not have to pay for amenities that have no impact on patient care.

In addition to maintaining individuals' basic rights within a nursing facility, it is important that such rights are also maintained at the time of a transfer or discharge. A very clear way of maintaining quality care is to ensure that the patient has access to contacts outside, as well as outside persons such, as the long-term care ombudsman, having access to the patient.

While we agree with the proposal for preadmission screening and resident review for mentally ill and mentally retarded, we have problems with some of the requirements associated with the proposal. Such individuals need to receive appropriate care, which they may not get in a nursing facility. But the provision seems to require states to provide active treatment to

INDIVIDUALS WITH NO FEDERAL FINANCIAL PARTICIPATION. WE OBJECT TO BEING REQUIRED TO FURNISH SERVICES BY THE FEDERAL GOVERNMENT, WHEN THE FEDERAL GOVERNMENT IS NOT GOING TO PARTICIPATE IN THE FINANCING OF SUCH SERVICES. THIS PROPOSAL APPEARS TO BE ADDRESSING THE VERY DIFFICULT ISSUE OF PROVIDING APPROPRIATE TREATMENT TO THE MENTALLY ILL AND MENTALLY RETARDED IN A VERY LIMITED WAY. THE STATES AGREE THERE ARE PROBLEMS, BUT FEEL A MORE COMPREHENSIVE AND FINANCIALLY EQUITABLE SOLUTION IS NEEDED THAN IS PROPOSED IN THE BILL.

WE SUPPORT THE PROPOSED REQUIREMENTS RELATED TO ADMINISTRATION. WE ALSO SUPPORT REQUIREMENTS THAT NURSING FACILITIES MEET AND MAINTAIN ALL FEDERAL, STATE AND LOCAL STANDARDS REGARDING LICENSURE, LIFE SAFETY CODES, SANITARY AND INFECTION CONTROL AND OTHER STANDARDS RELATED TO THE HEALTH AND SAFETY OF THE PATIENTS.

RESIDENT ASSESSMENTS (SECTION 3)

THE STATE MEDICAID AGENCIES SUPPORT THE IDEA OF DEVELOPING A SINGLE UNIFORM ASSESSMENT TO EVALUATE A RESIDENT'S ABILITY TO PERFORM DAILY LIFE FUNCTIONS. SUCH AN ASSESSMENT INSTRUMENT, AS MORE CLEARLY ENVISIONED IN THE IOM STUDY, WOULD EMPHASIZE EVALUATING THE RESIDENT'S CONDITION AND CARE RATHER THAN THE REQUIREMENTS OF PAPERWORK AND PHYSICAL PLANT THAT ARE CURRENTLY EMPHASIZED. AS PRESCRIBED IN SECTION 2 OF THE BILL, THIS ASSESSMENT INSTRUMENT WOULD BE USED UPON ADMISSION, PERIODICALLY

THEREAFTER, AND PROMPTLY AFTER EACH SIGNIFICANT CHANGE IN THE RESIDENT'S PHYSICAL OR MENTAL CONDITION. THE MERIT OF THIS PROPOSAL IS CLEAR.

WE ARE PARTICULARLY PLEASED THAT THE BILL CALLS FOR EXCEPTIONS TO A SINGLE NATIONAL ASSESSMENT INSTRUMENT, IF STATES RECEIVE APPROVAL FROM THE SECRETARY. IN A VARIETY OF PROGRAM AREAS STATES HAVE FOUND THAT WHAT IS REALLY DESIRED IS UNIFORM ITEMS AND DEFINITIONS, NOT A UNIFORM INSTRUMENT. TOO OFTEN USING A SINGLE FORM THROUGHOUT THE COUNTRY HAS NEGATIVE IMPACT AND PREVENTS STATES FROM DOING MORE THAN THEY ARE REQUIRE BECAUSE A DESIGNATED FORM WILL NOT ALLOW THEM TO DO MORE. THE FLEXIBILITY PROVIDED BY THE BILL SHOULD AVOID SUCH A PROBLEM.

## SURVEY AND CERTIFICATION (SECTION 4)

USING A TWO-STEP SURVEYING PROCESS WHICH TARGETS MONITORING RESOURCES TOWARD PROBLEM NURSING FACILITIES IS AN EXCELLENT IDEA. THE CURRENT REVIEW PROCESS WHICH CALLS FOR 100 PERCENT REVIEW OF PATIENT RECORDS REGARDLESS OF THE CARE PROVIDED BY THE FACILITY LEADS TO A GREAT DEAL OF WASTED EFFORT. BY USING SAMPLING TECHNIQUES IN A STANDARD SURVEY OF ALL FACILITIES, THE STATES CAN EXTEND A MUCH GREATER AMOUNT OF THEIR MONITORING RESOURCES TO PROBLEM FACILITIES THROUGH EXTENDED SURVEYS.

Establishing unannounced surveys for nursing facilities not earlier than 9 months, nor later than 15 months, is another very good idea. If these surveys are to provide proper oversight it seems logical that a regular 12 month review pattern should be avoided. Some substandard facilities have avoided detection because the surveys are so predictable. I would point out that although facilities may currently escape exposure for physical deficiencies that are easily corrected before a survey, poor care provided to a patient over an extended period cannot be quickly remedied by the facilities. We believe that the 12 month surveys have been catching such problems.

Combining the inspection of care (IOC) and survey and certification processes is basically a sound idea, but state Medicaid agencies do have some reservations. Because both the IOC and survey and certification process are carried out by teams with similar professional personnel at different times, combining the two process will save the state and federal governments funds in terms of personnel and travel, and it will reduce the paperwork requirements for the nursing facilities. In addition this provision would do away with the physician recertification requirements, and the associated penalties, and we most definitely support such a move. Physician recertification has ceased to be an issue of care, but rather a fiscal issue between state Medicaid agencies and HCFA auditors.

DESPITE THESE POTENTIAL BENEFITS FROM COMBINING THE TWO PROCESSES, THE STATE MEDICAID AGENCIES HAVE SOME RESERVATIONS ABOUT THE PROPOSAL. LET ME EXPOSE SOME BIASES OF STATE MEDICAID DIRECTORS. WE TEND TO THINK THAT IOC TEAMS, UNDER OUR CONTROL, FOCUS MORE ON THE CARE PATIENTS ARE RECEIVING AND WHETHER THEY ARE APPROPRIATELY PLACED, WHILE SURVEY AND CERTIFICATION TEAMS, OFTEN NOT UNDER OUR CONTROL, EMPHASIZE THE PHYSICAL PLANT OF A NURSING FACILITY.

IN THE OPINION OF THE STATE MEDICAID DIRECTORS, CONTROL OR INFLUENCE WITH THE SURVEYING ACTIVITY WOULD BECOME PARTICULARLY IMPORTANT BECAUSE IT WOULD BE THE ONE REVIEW OF HOW MEDICAID DOLLARS ARE BEING SPENT. WHILE THIS LEGISLATION WOULD COMBINE THESE ACTIVITIES, THE RESPONSIBILITY FOR THE QUALITY OF LIFE AND NURSING CARE RECEIVED BY MEDICAID RESIDENTS IS THE RESPONSIBILITY OF OUR AGENCY. WE NEED A DIRECT RELATIONSHIP WITH THIS ACTIVITY IF WE ARE TO HAVE THIS RESPONSIBILITY AND PAY FOR THE CARE. AS ADMINISTRATORS OF THIS MULTI-BILLION DOLLAR PROGRAM WE FEEL MORE CONFIDENT WHEN WE HAVE CONTROL OVER THE REVIEW OF THE QUALITY OF SERVICE OUR CLIENTS ARE BEING PROVIDED. THIS IS NOT TO SAY SURVEY AND CERTIFICATION PERSONNEL DO A BAD JOB, ONLY THAT IN MANY STATES WE ARE NOT CURRENTLY DEEPLY INVOLVED IN THAT PROCESS AND GIVING UP OUR REVIEW TOOL, THE IOC, MAKES SOME OF US UNEASY.

SEVERAL STATES HAVE, HOWEVER, ALREADY COMBINED THEIR IOC AND SURVEY AND CERTIFICATION EFFORTS AND ARE PLEASED WITH THIS APPROACH. WE BELIEVE THAT THE SOLUTION TO OUR CONCERN IS

CONTAINED IN THE BILL, WHICH WOULD ALLOW STATES TO CONTINUE INSPECTION OF CARE ACTIVITIES WITH FEDERAL FINANCIAL PARTICIPATION IF THEY CHOOSE. THIS WILL ALLOW EACH STATE TO WORK TOWARD AN APPROPRIATE BALANCE OF THE TWO ACTIVITIES.

WE ARE OPPOSED TO THE PROPOSED FISCAL PENALTY ON STATES THAT ARE FOUND TO HAVE INADEQUATE SURVEY AND CERTIFICATION EFFORTS. WHY TAKE MONEY AWAY FROM AN EFFORT THAT IS ALREADY INADEQUATE? HOW CAN IMPROVEMENT OCCUR WITH FEWER FUNDS? THE STATES BELIEVE THAT THERE ARE ALREADY ADEQUATE INCENTIVES IN PLACE TO ENSURE THAT SUBSTANDARD SURVEYING DOES NOT BECOME A REGULARITY. WE SUPPORT FEDERAL "LOOK-BEHIND" REVIEWS THAT CHECK STATES' EFFORTS, AND STATE MEDICAID AGENCIES ARE ALWAYS SUBJECT TO PENALTIES IN BENEFIT DOLLARS IF THESE REVIEWS SHOW THAT INADEQUATE CARE IS BEING PROVIDED.

WE SUPPORT A HIGH PERCENTAGE OF FEDERAL FUNDING FOR THE FIRST THREE YEARS OF THE NEW SURVEY AND CERTIFICATION PROCESS. WHILE THE MONITORING CHANGES WILL REAP FINANCIAL SAVINGS FOR STATE AND FEDERAL GOVERNMENTS, THE TRANSITION MAY BE EXPENSIVE.

IN ORDER FOR THE CHANGE TO OCCUR SMOOTHLY THE ADDITIONAL FEDERAL FUNDS ARE NEEDED FOR A LIMITED TIME. WE ARE PARTICULARLY PLEASED WITH THIS SUGGESTION AT THE SAME TIME THE ADMINISTRATION HAS PROPOSED TO ELIMINATE ALL ENHANCED FUNDING FOR THE MEDICAID PROGRAM.

RECENTLY, AND WITHOUT LEGISLATION, HCFA WROTE INTO REGULATION A NEW AND MUCH MORE NARROW DEFINITION OF "SKILLED PROFESSIONAL MEDICAL PERSONNEL" FOR WHOSE SERVICES STATES RECEIVE 75 PERCENT FEDERAL FUNDING. THIS SUDDEN CHANGE IN DEFINITION AFTER 20 YEARS EFFECTIVELY REDUCED FEDERAL FUNDING TO STATES. THE STATES BELIEVE THAT ENHANCED FEDERAL FUNDING IS AN APPROPRIATE MEANS OF ESTABLISHING PROGRAM PRIORITIES.

ENFORCEMENT (SECTION 5)

WE GENERALLY SUPPORT THE RECOMMENDATIONS REGARDING THE ENFORCEMENT PROCESS, PARTICULARLY TO PUT IN PLACE STATE AND FEDERAL AUTHORITY TO USE INTERMEDIATE SANCTIONS TO ENFORCE COMPLIANCE AGAINST NURSING FACILITIES. MANY STATES HAVE ALREADY ESTABLISHED INTERMEDIATE SANCTIONS AT THE STATE LEVEL, BUT FEDERAL CONFIRMATION OF THIS ACTIVITY CAN PROVIDE ADDITIONAL SUPPORT TO THE STATES. THE CURRENT FEDERAL PENALTIES THAT CALL FOR EXPELLING A PROVIDER FROM THE PROGRAM AND NOTHING LESS ARE UNREALISTIC BECAUSE THEY POTENTIALLY HURT THE PATIENT AND NOT THE PROVIDER.

I WOULD ADD ONE WORD OF CAUTION REGARDING THE STRENGTHENING OF SANCTIONS AND TIGHTENING OF THE APPEALS PROCESS. GIVE STATES DISCRETION IN HOW THESE ARE APPLIED. IF INTERMEDIATE SANCTIONS ARE MEANT TO GIVE STATES MORE LATITUDE IN DEALING WITH PROVIDERS, THEN PARTICULAR SANCTIONS SHOULD NOT BE TIED MANDATORILY TO SPECIFIC VIOLATIONS.

THANK YOU FOR ASKING ME TO COMMENT ON H.R. 2270. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

Mr. **Waxman**. Thank you, Mr. Johnson.
Ms. Marshall.

### STATEMENT OF MARY A. MARSHALL

Ms. **Marshall**. Mr. Chairman and members of the committee, I am delegate Mary Marshall. I'm in the Virginia House. I chair the NCSL Long-Term Care Task Force and was on the Long-Term Care Subcommittee of the Federal Council on Aging and chaired the Joint Study Committee on Long-Term Care for the Virginia General Assembly, so I've been long interested in long-term care.

The statement you have there is the policy of the National Conference of State Legislatures, adopted last week at a meeting at which 40 States were represented.

We have also completed two studies that will be interesting to you. My task force is about to publish a Legislator's Guide to Long-Term Care. We will make copies available to you. And we have done a survey of State legislatures' issues concerning the elderly, and we will make that available to you.

We support this legislation very vigorously, very strongly. We think that a patient-oriented system of evaluation in the plan of care, the assessment instrument, a system of inspecting on the basis of where it is needed most, all will be very beneficial to patients and to taxpayers.

We do suggest that fiscal incentives to the States and nursing homes to implement the new requirements will speed up the implementation. We urge an adequate transition period. It takes awhile for people to learn a new way of doing things, and while to train the people who train the people, and we hope you will allow time for that, and that you will set the schedule up so that we develop the standards and the processes before we develop the penalties, or at least they go hand in hand.

And we support intermediate sanctions. As I say, we emphasize sufficient time. We believe that you should prohibit facilities from discriminating against individuals who receive Medicaid. But we do want to point out that this would be a problem with continuing care, retirement communities, and you need an exemption for them to be able to take care of their own residents, who are already paying for their care.

We urge you to recognize State laws on the division of assets of married couples, as I'm sure you know in California, where you have a community property law. This is ignored by the Medicaid administration and the spouse is impoverished, in spite of what the State law says about what belongs to her—it's not always her.

We urge you to look very carefully at the prescreening program, so that you don't back people up in hospitals. Virginia was the first State to have a prescreening program. We went about it very slowly, and we never had this problem. But other places have found that if they enact a prescreening program and don't manage to get everything in place quickly enough, you back people up in hospitals, which is very bad for your Medicaid budget and hard on the people along with the hospitals.

We urge as much flexibility as you can possibly put into it, so that the States can develop—continue to develop their own programs, and we will be happy to work with you in any way that we can to get this legislation moving forward.

[The prepared statement of Ms. Marshall follows:]

### STATEMENT OF MARY A. MARSHALL

Mr. Chairman and distinguished members of the subcommittee:

I am Mary A. Marshall, State delegate from Virginia, and chairman of the assembly's Committee on Counties, Cities and Towns, and vice chair of the Committee on Health, Welfare and Institutions. I am from Arlington on represent the State's 48th district. I have been in the assembly for 19 years. I would like me full statement to become part of the hearing records.

It is pleasure to be here today representing the National Conference of State Legislatures (NCSL) to share our views on H.R. 2270, "the Medicaid Nursing Home Quality of Care Amendments of 1987." I am a member of the NCSL Health and Human Services Committee, and I also chair their task force on Long Term Care Care for the Elderly. I was also the former chair of the assembly's Joint Committee on Long Term Care and a former member of the Federal Council on Aging's Long Term Care Task Force, thus my perspective is a broad one and this issue has been an interest of mine for sometime.

As you may be aware, NCSL has just completed a meeting of its State-Federal Assembly (SFA) here in Washington, where extensive debate on the subject of long-term care took place. NCSL's Health and Human Services Committee revised our long-term care policy and the resolution was adopted, unanimously, at the State-Federal assembly. It is expected to be adopted as policy for the conference at NCSL's annual meeting later this summer. The policy will be the basis of our lobbying position on "the Medicaid Nursing Home Quality of Care Amendments of 1987," (H.R. 2270).

Second, NCSL recently completed work on two new publications, one is a 50-State survey entitled, "State Legislative Issues Concerning the Elderly," 1986–1990." The other is entitled, "Long Term Care for the Elderly: A Legislators Guide." We will send copies of these publications to the subcommittee as soon as they are available from the publishers. I should point out that the legislators' guide was a project that my task force worked on for over 1 year and it was supported by a grant from the American Association of Retired Persons (AARP) and our Health Care Cost Containment Project Grant from the Health Care Financing Administration (HCFA).

I want to comment the committee on developing this legislation and bringing the issue to Congress' attention. The National Conference of State Legislatures supports efforts by the Federal Government to improve Federal and State regulation of nursing homes. Such a task will require coordination and cooperation by every branch of government. Patients and taxpayers will benefit from the proposed nursing home reform legislation which includes requirements for a new inspection system, to look at the welfare of the patients rather than the condition of their records and improved training for nurses aides which is probably the most important step for better care. Briefly, I would like to share with you some of the concerns NCSL has with this legislation and offer a few suggestions to improve it.

The National Conference of State Legislatures (NCSL) supports a goal to assure a high quality of care and a high quality of life in all the Nation's nursing homes. It is essential to reduce duplication of oversight responsibilities and maintain good quality care.

In 1986, the Institute of Medicine (IOM) of the National Academy of Sciences, released a report on improving the quality of care in nursing homes. Development of these recommendation have been followed closely by the U.S. House of Representatives Committee on Energy and Commerce and by the Health Care Financing Administration (HCFA). NCSL commends each of these entities for their leadership in dealing with this complex, difficult and sensitive problem. NCSL calls for continued communication and cooperation between these groups and the States while the recommendations are implemented.

NCSL supports the establishment of a national comprehensive nursing home reform policy which is patient outcome-based and includes quality assessment and monitoring systems that target inspections on facilities with a history of noncompliance with existing standards. Facilities with superior compliance records should be monitored less often and undergo a less rigorous survey.

Due to the potential for significant increased in cost to facilities and to States for compliance with new requirements, NCSL call upon the Federal Government to provide: (1) fiscal incentives to States and nursing facilities to implement these new requirements; and (2) an adequate transition period. In addition, intermediate sanctions for States and nursing facilities who do not meet the target date for implementation established in law should be provided.

NCSL believes it is important for surveys or assessment to be made of nursing facility residents to ascertain in steps necessary to: improve the quality of care and services, upgrade facilities and training programs, design plans of care, and determine the cost of implementation. Sufficient time should be provided for the development of new survey instruments, the training of personnel, the development of State regulations and the adoption of new requirements. Federal assistance should be available to facilities and the States to perform these tasks.

Elimination of duplicative surveys and certification requirements should be the first priority of new Federal conditions of participation by nursing facilities. Consolidation of Medicare, Medicaid, and State certification processes should be implemented.

Federal rules should prohibit facilities from discrimination against individuals who receive Medicaid payments for long-term care.

States should be permitted to establish Medicaid eligibility standards which recognize State laws regulating the division of assets and income for married couples. States should assure standards to minimize spousal impoverishment in the division of spousal income.

New Federal requirements should not inhibit the flow of patients into nursing facilities, and "new patient assessment" requirements should not cause the untimely or early discharge of patients if the required level of nursing home care is unavailable.

Federal requirements for States regarding standards for nursing facilities should provide States with needed flexibility to set requirements that are consistent with the needs of the State.

Finally, the Secretary should be required to consult with State legislatures and State long-term care officials when developing new criteria for regulation of State facilities, and developing minimum standards for professional training requirements.

In conclusion, a great deal remains to be done and NCSL calls upon the Federal Government to work with States, localities, consumers, and provides to formulate a national comprehensive long-term care policy to meet the needs of the elderly, and the physically and mentally disabled. In addition, NCSL also asks the Federal Government to ease the demands placed on the Medicaid program to provide service to the country's expanding elderly population. Improving State and Federal regulation of nursing homes is an important step in that direction.

On behalf of the National Conference of State Legislatures I thank you for this opportunity to share our views with you. I hope that they have been helpful and will result in the revisions that will enable us to put the full force of the Nation's State lawmakers behind your legislation. The conference looks forward to working closely with you and your staff over the coming months on this most important issue.

Mr. WAXMAN. Thank you very much, Ms. Marshall.

Ms. Saros.

### STATEMENT OF ILEANA N. SAROS

Ms. SAROS. Mr. Chairman, I am Ileana N. Saros, president of the National Association of Medicaid Fraud Control Units.

The mandate of the State units is not only to investigate and prosecute provider fraud, but also to monitor and respond to patient abuse occurring in nursing homes that receive Medicaid funds. Based upon our experiences, we applaud the intent of this bill, its philosophy, and the thrust of its specific recommendations.

We are pleased that the present proposal has incorporated a number of important changes that we recommended to the committee. We trust that our comments today and our continuing discussions with the committee will also assist you.

We commend the provisions banning both coerced donations and the waiver of the right to apply for Medicaid. We recommend that the solicitation of donations be prohibited not only as a condition of admission, but also as a condition of expediting admission. We believe the statement of a right to equal treatment, despite source of payment, is important and necessary.

As recognized by the bill, unannounced and unanticipated survey visits are essential in determining a nursing home's compliance with Federal and State regulation. Exemplifying the problem in this area is the experience of one State where surveyors worked in the field for approximately a 2-week period. Agency secretaries would forward their messages to the next facility on the itinerary for delivery, thereby notifying the facility of his expected arrival. We strongly urge passage of the provisions that would require and ensure that each State adopt measures guaranteeing that unannounced visits are indeed a surprise.

The provisions regarding patient funds constitute an important step; however, we suggest two additions. First, nursing homes need the discipline and accountability of routine quarterly reporting to residents. Second, regulations must specify the disposition of patient funds upon the death of the resident and require that funds be turned over in a timely manner and with a final accounting to the patient's estate or the public administrator.

The provision of training for nurse's aides is a reform that the fraud control units have long sought. Nurse's aides are involved in the bulk of the patient abuse cases that we deal with. We welcome the training provisions in the bill and offer the following suggestions:

The use of per diem or temporary aides is common practice in many locations. The legislation must be unequivocally clear that no per diem aides may work at a nursing facility unless they have the same training as the aides employed by the facility. We question the wisdom of permitting either per diem employers or employee organizations to conduct the training program. Both have potential conflicts of interest, and both will be difficult to supervise.

Another aspect of per diem employment demanding attention is orientation. The requirement of orientation must be expanded to include the per diem employees before they engage in patient care.

The issue of screening aides is a difficult one, but it must be addressed. An important factor in the screening process is the requirement of criminal record checks tied to mandatory exclusion for past misconduct related to the duties performed in the nursing home.

However, most patient abuse activity does not result in a criminal record. Therefore, the screening process must include an assessment of the person's past performance in positions as aides or in other human services positions. The State must be able to track an employee from position to position. We propose that this committee consider establishing a registry, coupled with a patient abuse reporting requirement. The registry could also serve the purpose of recording the criminal history information and documenting the proof of training.

We strongly support the provisions strengthening interim sanctions. Our units concur in the conclusion that the all-or-nothing character of existing sanctions makes administrative agencies reluctant to use them. From a law enforcement point of view, financial sanctions are most effective when applied routinely, consistently, and without discretion. Temporary management or receivership, as proposed by the committee, is an important second tool in the hierarchy of interim sanctions. We strongly recommend that after a prescribed period of time, it becomes automatic.

We also recommend that any facility placed into receivership bear the cost of providing the temporary management. The legislation should further require the States to promulgate standards for receivers and temporary management to guard against conflicts of interest, ensure minimum qualifications, and create a pool of receivers readily available for appointment.

In conclusion, the initiative of this committee heralds an important and progressive year for the nursing home industry and, more importantly, for the hundreds of thousands of patients who depend upon the industry for health and nurture. We look forward to a vigorous and productive discussion as to how best to protect the vital interests of nursing home patients. We pledge to his committee that our Association will make every effort to assist and participate in this crucial cause.

Thank you.

Mr. **Waxman**. Thank you very much for your testimony.

[Testimony resumes on p. 444.]

[The prepared statement of Ms. Saros follows:]

## STATEMENT OF NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM ILEANA SAROS, PRESIDENT OF THE NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS. I HAD HOPED THAT MR. ALBERT APPLETON OF NEW YORK, THE ASSOCIATION LEGISLATIVE CHAIRMAN WHO COORDINATED THE PREPARATION OF THIS TESTIMONY FOR THE ASSOCIATION, WOULD BE HERE AS WELL, BUT HE WAS UNABLE TO BE IN WASHINGTON TODAY DUE TO LONGSTANDING SCHEDULE CONFLICTS. I WOULD ALSO LIKE TO ACKNOWLEDGE THE WORK OF OUR OTHER LEGISLATIVE COMMITTEE MEMBERS, THE UNIT DIRECTORS FROM NORTH CAROLINA, DELAWARE, CONNECTICUT, INDIANA, AND CALIFORNIA, AS WELL AS THE ASSISTANCE OF BEA CLOSE AND MARY SUGHRUE, PATIENT ABUSE AND COMMUNITY AFFAIRS DIRECTORS RESPECTIVELY FOR THE NEW YORK STATE MEDICAID FRAUD CONTROL UNIT.

WE ARE VERY PLEASED TO ONCE AGAIN BE APPEARING BEFORE YOUR COMMITTEE. THE CONTINUING SUPPORT OF THE HEALTH AND ENVIRONMENT SUBCOMMITTEE FOR THE FRAUD UNIT PROGRAM IN THE LEGISLATIVE AND BUDGET BATTLES OF THE LAST DECADE HAS BEEN INDISPENSABLE TO OUR SUCCESS. I WOULD LIKE TO EXPRESS THE GRATITUDE OF OUR 38 STATE UNITS FOR YOUR CONTINUING COMMITMENT TO PROTECT THE PROGRAMS THAT PROVIDE CRUCIAL HEALTH CARE SERVICES TO OUR POOR AND AGED POPULATIONS FROM THE CONTINUING THREATS OF FRAUD AND PATIENT ABUSE, AND SALUTE YOUR COMMITTEE'S FARSIGHTED LEADERSHIP IN NOT ONLY ESTABLISHING BUT VIGOROUSLY PROTECTING THE MEDICAID FRAUD CONTROL UNIT PROGRAM.

TEN YEARS AGO THIS SPRING THIS COMMITTEE SPONSORED THE LEGISLATION THAT LED TO THE ESTABLISHMENT OF THE FRAUD UNIT PROGRAM. TODAY, THERE ARE FRAUD UNITS IN 38 STATES. OVER THE LAST DECADE, THOSE UNITS HAVE PROSECUTED TO CONVICTION OVER 2400 FRAUDULENT MEDICAID PROVIDERS, INVESTIGATED MANY THOUSANDS MORE AND RECOVERED TENS OF MILLIONS OF DOLLARS. IN ADDITION, THERE IS AMPLE EVIDENCE THAT THE FRAUD UNIT PROGRAM HAS FULFILLED THE HOPES OF ITS CONGRESSIONAL SPONSORS OF PROTECTING TAXPAYER FUNDS THROUGH THE DETERRENT IMPACT OF VIGOROUS PROSECUTION OF MEDICAID FRAUD. STUDIES OF INDUSTRY BILLING PATTERNS IN NEW YORK, CALIFORNIA, OHIO, INDIANA, MASSACHUSETTS AND MICHIGAN HAVE CONSISTENTLY SHOWN SIGNIFICANT DROPS IN MEDICAID BILLINGS FOLLOWING FRAUD UNIT INDICTMENTS. AS MARK TWAIN APTLY NOTED, "WE WILL NEVER DO WRONG WHEN PEOPLE ARE LOOKING." THE FRAUD UNITS STAND AS A CONSTANT REMINDER TO PROVIDERS THAT THE PUBLIC IS LOOKING.

WE LOOK NOT ONLY AT POTENTIAL FRAUD, WE LOOK FOR PATIENT ABUSE. WE ARE SPECIFICALLY MANDATED TO MONITOR AND RESPOND TO PATIENT ABUSE OCCURRING IN NURSING HOMES AND OTHER MEDICAID SUPPORTED HEALTH CARE PROGRAMS. THIS IS A MANDATE WE HAVE VIGOROUSLY PURSUED DESPITE NUMEROUS OBSTACLES.

MOST STATE CRIMINAL LAWS ARE ILL-SUITED FOR USE IN PATIENT ABUSE PROSECUTION, THE MOST VULNERABLE ELDERLY ARE THE LEAST ABLE TO TESTIFY IN COURT, AT TIMES ADMINISTRATIVE AGENCIES HAVE BEEN INDIFFERENT OR EVEN RESENTFUL OF OUR PATIENT ABUSE ROLE, AND FEDERAL HEALTH AND HUMAN SERVICE REGULATORS ARE EXHIBITING A TENDENCY TO JUDGE THE SUCCESS OF FRAUD UNIT PROGRAM PRIMARILY BY A BOUNTY HUNTING STANDARD OF DOLLARS RECOVERED. YET WE HAVE FORGED AHEAD AND PLAYED, I BELIEVE WE CAN SAY, A LEADERSHIP ROLE IN COMBATTING THE MISTREATMENT OF NURSING HOME PATIENTS.

PATIENT ABUSE HAS MANY ASPECTS. IT MAY TAKE THE FORM OF PHYSICAL, SEXUAL OR FINANCIAL ABUSE, IT MAY INVOLVE NEGLECT RATHER THAN AGGRESSION, OR DISCRIMINATION AGAINST MEDICAID ELIGIBLE PATIENTS. IN THE PAST YEAR, INVESTIGATIONS AND PROSECUTIONS OF FINANCIAL ABUSE HAVE BEEN CONDUCTED BY FRAUD UNITS IN CALIFORNIA, NORTH CAROLINA, TEXAS, NEW JERSEY, PENNSYLVANIA AND FLORIDA. SEXUAL ABUSE CASES HAVE BEEN BROUGHT BY THE MINNESOTA, DELAWARE AND NEW YORK UNITS; PHYSICAL ABUSE CASES BY THE ARKANSAS, MICHIGAN, MAINE, NEW YORK AND NORTH CAROLINA UNITS; AND NEGLECT CASES BY THE COLORADO, WISCONSIN AND NEW JERSEY UNITS.

DISCRIMINATION BY NURSING HOMES AGAINST MEDICAID PATIENTS HAS BEEN INVESTIGATED BY UNITS IN MASSACHUSETTS, NEW JERSEY AND NEW YORK. NEW YORK RECENTLY COMPLETED A SPARKLING UNDERCOVER INVESTIGATION USING AN 80 YEAR OLD VOLUNTEER CITIZEN "STING" THAT LED TO THE CONVICTION OF TWO MAJOR NON-PROFIT NURSING HOMES FOR ILLEGALLY SOLICITING DONATIONS AS A CONDITION OF ADMISSION. THE DELAWARE AND NORTH CAROLINA UNITS HAVE TAKEN A LEAD IN SEEKING LEGISLATION TO STRENGTHEN THEIR STATE LAWS AGAINST PATIENT ABUSE AND FACILITATE PROSECUTION, AS HAVE OHIO, MICHIGAN AND NEW YORK IN PRIOR YEARS.

OVER THE LAST DECADE, REVIEW OF NURSING HOME INDUSTRY PRACTICE BY VARIOUS UNITS HAS LED TO IDENTIFYING MANY SPECIFIC PROBLEMS IN INDUSTRY PRACTICE, INCLUDING FIRE SAFETY, SUMMER AIR-CONDITIONING, THE MISUSE OF PATIENT RESTRAINTS, THE MISHANDLING OF PATIENT FUNDS, FAILURES OF PROPER SURVEY AND ADMINISTRATION, THE VIRTUAL ABSENCE OF EFFECTIVE PROFESSIONAL CONDUCT REVIEW, AND THE NEED FOR TIGHTENED STANDARDS AND TRAINING FOR NURSING HOME AIDES. OURS IS A PRACTICAL, HANDS-ON VIEWPOINT AND FROM IT WE SHARE THE GENERAL SENSE THAT IT IS TIME FOR LEGISLATORS, REGULATORS AND ALL CONCERNED WITH NURSING HOMES - AN INDUSTRY WHOSE POSSIBLE FUTURE USE IS NOW AN UNAVOIDABLE CONSIDERATION IN THE LIFE PLANS OF ALL AMERICANS - THAT THE TIME HAS COME TO TAKE A NEW LOOK AT HOW IT CAN BE MANAGED BETTER.

WE THEREFORE APPLAUD THIS BILL. WE APPLAUD ITS INTENT, ITS BASIC PHILOSOPHY AND THE THRUST OF ITS SPECIFIC RECOMMENDATIONS. WE NOTE WITH SATISFACTION THAT THE PROPOSAL CURRENTLY BEING CONSIDERED HAS INCORPORATED A NUMBER OF IMPORTANT CHANGES WE RECOMMENDED TO THE COMMITTEE. WE HOPE THAT OUR COMMENTS TODAY AND OUR CONTINUING DISCUSSIONS WITH YOU WILL BE EQUALLY HELPFUL TO YOU IN YOUR DELIBERATIONS.

WE WOULD OPEN OUR SPECIFIC COMMENTS WITH AN IMPORTANT CAUTION. THESE REFORMS ARE NEEDED, THEY WILL PROVIDE A BASIS FOR MORE RESPONSIVE AND EFFECTIVE REGULATION OF NURSING HOME CARE, THEY WILL BENEFIT PATIENTS. AT THE SAME TIME, ANY SYSTEM OF REGULATION IS ONLY AS GOOD AS THOSE WHO USE IT WANT TO MAKE IT. EXISTING NURSING HOME REGULATION HAS SIGNIFICANT GAPS THAT THIS LEGISLATION WILL HOPEFULLY CLOSE, BUT IT IS ALSO TRUE THAT EVEN EXISTING REGULATION HAS SIGNIFICANT POTENTIAL FOR PATIENT PROTECTION THAT HAS NEVER BEEN EXPLOITED. THE REASONS ARE THE STANDARD ONES: A LACK OF ENFORCEMENT RESOURCES, A LACK OF POLITICAL WILL. ONCE THIS LEGISLATION IS PASSED, WE WILL STILL NEED ADEQUATE RESOURCES AND ADEQUATE POLITICAL WILL TO MAKE IT THE TOOL FOR PATIENT PROTECTION THIS COMMITTEE SEEKS TO CREATE.

IT IS OFTEN OBSERVED THAT AMERICA IS A COUNTRY OF LAWS. BUT IT IS LESS OFTEN OBSERVED, OR EVEN ACKNOWLEDGED, THAT TOO OFTEN WE ARE NOT A COUNTRY OF ENFORCED LAWS.

THUS, IN PASSING THIS LEGISLATION, CONGRESS SHOULD GIVE THOUGHT TO INSURING ITS PROPER IMPLEMENTATION. OTHERWISE, CONGRESS WILL DISCHARGE ONLY PART OF ITS LEADERSHIP TASK.

THE MOST IMPORTANT STEP CONGRESS COULD TAKE TO INSURE THE LAW IS VIGOROUSLY ENFORCED WOULD BE TO SPONSOR IN EVERY POSSIBLE WAY LINKAGES BETWEEN NURSING FACILITIES AND THE COMMUNITIES THEY ARE SERVING. EVERYTHING POSSIBLE SHOULD BE DONE TO PROMOTE A FLOW OF INDIVIDUALS INTO AND INTERACTING WITH THE FACILITY, TO COUNTERACT THE OUT-OF-SIGHT, OUT-OF-MIND SYNDROME THAT SETS THE STAGE FOR REGULATORY PUNCH-PULLING. THUS WE APPLAUD THE PROVISIONS IN THIS LEGISLATION TO MORE DEFINITIVELY STATE THE RIGHT OF PATIENTS AND FAMILIES TO CONTROL THEIR OWN TREATMENT AND TO BE INTIMATELY AND MATTER OF FACTLY INVOLVED IN ITS DECISION-MAKING; TO ENCOURAGE AND STRENGTHEN OMBUDSMAN AND ADVOCACY PROGRAMS; AND TO DIRECT MORE PUBLIC DISCLOSURE OF SURVEY RESULTS AND OTHER INFORMATION RELEVANT TO ASSESSING NURSING HOME PERFORMANCE.

p. 7, FRAUD UNIT TESTIMONY

THE EXPERIENCES OF OUR UNITS WITH FAMILY ATTITUDES DURING OUR INVESTIGATIONS OF COERCED DONATIONS AND OTHER NURSING HOME ABUSES ARE MOST REVEALING. THEIR FEARS THAT COMING FORWARD MEANS LOSING A TREASURED BED, OFTEN OBTAINED AFTER GREAT DIFFICULTY AND ANXIETY, THEIR ANTICIPATION OF RETALIATION AGAINST THEIR LOVED ONES, SIGNIFY TO US A WIDESPREAD FEELING OF FAMILY FRUSTRATION AND HELPLESSNESS. THE INSTITUTIONAL SETTING, THE REGULATORY COMPLEXITY, THE ONGOING EMOTIONAL AND FINANCIAL STRAIN ALL CONSPIRE AGAINST A PATIENT AND A PATIENT'S FAMILY'S SENSE OF AUTONOMY AND AUTHORITY IN THE NURSING FACILITY SETTING. IF WE ARE INDEED SEEKING TO REORIENT NURSING HOME REGULATION TO MORE OUTCOME ORIENTED MEASURES, AN OUTCOME IT WILL BE PROFOUNDLY IMPORTANT TO MEASURE IS WHETHER A FACILITY IS PART OF A LARGER COMMUNITY OR HAS ISOLATED OR WALLED ITSELF OFF FROM IT.

ANOTHER TOPIC WE WOULD SPEAK TO IS ADMISSIONS DISCRIMINATION AGAINST MEDICAID PATIENTS. WHEREVER BEDS IN QUALITY FACILITIES ARE DIFFICULT TO FIND, THIS WILL BE A PROBLEM. TO MERELY REGARD THAT AS A FACT OF LIFE WOULD BE TO ACCEPT A TWO CLASS SYSTEM OF HEALTH CARE, A SYSTEM IT WAS ONE OF MEDICAID'S ORIGINAL GOALS TO ELIMINATE. THIS LEGISLATION COMMENDABLY ATTEMPTS TO PROTECT THAT IDEAL.

p. 8, FRAUD UNIT TESTIMONY

WE APPLAUD THE PROVISIONS BANNING WAIVERS OF RIGHTS TO APPLY FOR MEDICAID, THE NOTORIOUS DURATION OF STAY CONTRACTS. WE BELIEVE THE STATEMENT OF A RIGHT TO EQUAL TREATMENT FOR PATIENTS IN THE FACILITY IRREGARDLESS OF SOURCE OF PAYMENT IS IMPORTANT AND NEEDED. BUT, THE COMMITTEE COULD GO FARTHER. WE WOULD ADD TO THIS LEGISLATION A BAN ON DISCRIMINATION ON THE BASIS OF SOURCE OF PAYMENTS IN ADMITTING NEW PATIENTS. WE ALSO URGE AN ADDITION TO THE LIST OF PATIENT RIGHTS THAT STATES A RIGHT OF RESIDENCE, THAT RECOGNIZES THAT NURSING FACILITIES ARE NOT TRANSIENT QUARTERS, BUT HAVE BECOME FOR MANY THEIR PRIMARY RESIDENCE. IN THIS LIGHT, WE ARE PARTICULARLY DELIGHTED TO SEE THE COMMITTEE ADOPT OUR RECOMMENDATION THAT PATIENTS RETURNING FROM HOSPITAL CARE THAT HAS OUTLASTED THEIR BED HOLD PERIOD BE GIVEN THE FIRST AVAILABLE SEMI-PRIVATE BED FOR READMISSION. PROPERLY ENFORCED, THIS WILL FORECLOSE THE CURRENT TEMPTATION TO MISUSE THERAPEUTIC TRANSFER TO EXCHANGE MEDICAID FOR PRIVATE PAY PATIENTS.

WE ARE ALSO PLEASED TO SEE THE COMMITTEE ADOPT LANGUAGE TO ADDRESS OUR RECOMMENDATION TO DEAL WITH THE PROBLEM OF THE ANTICIPATED UNANNOUNCED VISIT.

THE VALUE OF UNANNOUNCED SURVEY VISITS HAS LONG BEEN RECOGNIZED. UNFORTUNATELY, WHERE NOW REQUIRED, THE EXPECTATION HAS GREATLY EXCEEDED THE EVENT. NURSING HOMES GENERALLY SEEM TO KNOW WHEN THE SURVEYORS ARE COMING.

p. 9, FRAUD UNIT TESTIMONY

THIS IS SELDOM, IN OUR EXPERIENCE AT LEAST, THE RESULT OF DIRECT CORRUPTION. SLOPPY BUREAUCRATIC PRACTICE IS THE EXPLANATION. WHAT ARE SOME OF THE MORE COMMON GIVEAWAYS? SURVEYORS VISIT THE SAME HOME AT ROUGHLY THE SAME TIME OF THE YEAR, YEAR AFTER YEAR. THEY SEND DATA FORMS OR OTHER DOCUMENTATION TO THE HOME TO BE COMPLETED IN ADVANCE OF THE VISIT, SO THEY CAN USE THEM IN THE SURVEY PROCESS. THEY VISIT ALL THE HOMES IN A PARTICULAR REGION OF THE STATE AT THE SAME TIME, CUEING EVERYONE IN THE VICINITY.

THE MOST REVEALING STORY COMES FROM A STATE THAT WILL REMAIN NAMELESS. IN THIS STATE, SURVEYORS WERE GOING OUT TO THE FIELD FOR TWO WEEK STRETCHES, LEAVING THEIR SCHEDULES IN THEIR OFFICE. HELPFUL AGENCY SUPPORT STAFF WOULD FORWARD THEIR MESSAGES TO THE NEXT HOME ON THEIR ITINERARY, ASKING THE FACILITY TO GIVE THEM TO THE SURVEYOR WHEN HE ARRIVED.

WE STRONGLY URGE PASSAGE OF THE PROVISIONS THAT WOULD REQUIRE THE SECRETARY TO INSURE THAT EACH STATE HAS ADOPTED MEASURES THAT WILL REASONABLY GUARANTEE THAT UNANNOUNCED VISITS ARE A GENUINE SURPRISE.

THE PROVISIONS WITH REGARDS TO RESIDENT FUNDS ARE AN IMPORTANT STEP, BUT WE SUGGEST TWO ADDITIONS. PROVIDERS NEED THE DISCIPLINE AND ACCOUNTABILITY OF ROUTINE QUARTERLY REPORTING TO RESIDENTS, WHILE IT IS AN IMPORTANT REINFORCEMENT OF THE RESIDENT PERCEPTION THAT PERSONAL FUNDS ARE REALLY THEIR OWN RESOURCES, NOT SOME MYSTERY POT OF MONEY THAT THEY MUST DICKER WITH THE HOME TO OBTAIN.

p. 10, FRAUD UNIT TESTIMONY

THE OTHER COMMON ABUSE IS THE DISPOSITION OF PATIENT FUNDS UPON THE DEATH OF A RESIDENT. WE HAVE SEEN NUMEROUS INSTANCES, EXPLAINED AWAY AS SLOPPY BOOKKEEPING WITH JUST ENOUGH AMBIGUITY TO PRECLUDE FRAUD PROSECUTION, WHERE FUNDS ARE KEPT INDEFINITELY, UNACCOUNTABLY MERGED, OR BILLED AGAINST FOR CHARGES BEFORE BEING TURNED OVER, OFTEN TO SOMEONE ELSE THAN THE PATIENT'S ESTATE. A REQUIREMENT THAT UPON A PATIENT'S DEATH SUCH FUNDS BE TURNED OVER IN A TIMELY FASHION WITH A FINAL ACCOUNTING TO THE PATIENT'S ESTATE OR THE PUBLIC ADMINISTRATOR (NOT THE NEXT OF KIN OR JUST ANY CONVENIENT RELATIVE) IS NEEDED.

THE PROVISION OF TRAINING FOR NURSES AIDES IS A REFORM THE FRAUD UNITS HAVE LONG SOUGHT. NURSES AIDES ARE INVOLVED IN THE VAST BULK OF THE PATIENT ABUSE CASES WE DEAL WITH AND PROVIDE THE BULK OF HANDS ON PATIENT CARE. WE WELCOME THE TRAINING PROVISIONS IN THIS BILL. WE HAVE SEVERAL SUGGESTIONS WITH REGARDS TO THEM.

THERE ARE MANY LOCATIONS IN WHICH THE USE OF PER DIEM OR TEMPORARY AIDES IS COMMON PRACTICE. TO INSURE ALL PATIENTS ARE TREATED BY TRAINED PERSONNEL, AND TO AVOID ARTIFICIALLY ENCOURAGING THE USE OF PER DIEMS TO AVOID TRAINING REQUIREMENTS, IT IS NECESSARY THAT THE LEGISLATION BE UNEQUIVOCALLY CLEAR THAT NO PER DIEM AIDE MAY WORK IN A NURSING FACILITY WHO HAS NOT HAD THE SAME TRAINING AS AN AIDE EMPLOYED BY THE FACILITY.

p. 11, FRAUD UNIT TESTIMONY

MOREOVER, THE NATURE OF PER DIEM EMPLOYMENT MAKES IT UNSUITABLE TO EXTEND TO PER DIEMS THE PROVISIONS THAT PERMIT FULL TIME AIDES EMPLOYMENT IF THEY ARE UNDERGOING TRAINING. WE URGE CONDITIONING THE USE OF TEMPORARY HELP ON THE WORKER HAVING ALREADY COMPLETED AN APPROVED TRAINING PROGRAM.

WE HAVE SERIOUS DOUBTS ABOUT THE WISDOM OF PERMITTING EITHER PER DIEM EMPLOYERS OR EMPLOYEE ORGANIZATIONS TO CONDUCT THE TRAINING PROGRAMS. BOTH HAVE POTENTIAL CONFLICTS OF INTEREST, BOTH WILL BE DIFFICULT TO SUPERVISE.

ANOTHER ASPECT OF PER DIEM EMPLOYMENT NEEDING ATTENTION IS ORIENTATION. THE BILL REQUIRES ORIENTATION ACTIVITY IN A NUMBER OF INSTANCES. ONE IT DOES NOT SEEM TO ADDRESS IS THE PER DIEM EMPLOYEE COMING INTO A NURSING FACILITY. THAT EMPLOYEE IS UNAWARE OF FACILITY ROUTINES, HAS NO KNOWLEDGE OF PATIENTS, MEDICAL PERSONNEL, POTENTIAL PROBLEMS, OR FACILITY EMERGENCY PROCEDURES. THE GENERAL RULE IS FIVE FAST MINUTES OF HERE'S WHAT YOU NEED TO KNOW. THERE SHOULD BE REQUIREMENTS FOR SUITABLE ORIENTATION OF ALL PER DIEM PERSONNEL BEFORE THEY ENGAGE IN PATIENT CARE AT A FACILITY.

THE QUESTION OF PRE-SCREENING AIDES IS A DIFFICULT AND WIDELY DEBATED ONE. SIMILAR DISCUSSIONS ARE TAKING PLACE IN AT LEAST TWO OTHER AREAS: DAY CARE, BOTH CHILD AND MENTAL HEALTH SERVICE; AND HOME HEALTH CARE. THE CRUX OF THE ISSUE IS THE MERIT OF CRIMINAL RECORD CHECKS, OFTEN TIED TO SOME FORM OF MANDATORY EXCLUSION FOR PAST MISCONDUCT.

p. 12, FRAUD UNIT TESTIMONY

WE BELIEVE CRIMINAL RECORD CHECKS WOULD BE HELPFUL. THE INFORMATION ON THE ISSUE IS LIMITED AND IN MANY ASPECTS LARGELY ANECDOTAL, BUT IT DOES SEEM THAT, IN MANY AREAS, A LARGE PORTION OF THE POPULATION NURSES AIDES ARE RECRUITED FROM HAS PRIOR LAW ENFORCEMENT INVOLVEMENT. WE MIGHT ADD, IN PASSING, THAT THE AREA IS LONG OVERDUE FOR A SYSTEMATIC ASSEMBLAGE OF SOME DATA ON THE ISSUE, ALTHOUGH THERE ARE PRIVACY OBSTACLES THAT ARE RIGHTLY FORMIDABLE TO SO DOING.

WE ARE LESS PERSUADED THAT PROPOSED MANDATORY EMPLOYMENT EXCLUSIONS BASED ON A PRIOR CONVICTION FOR A PARTICULAR CRIME ARE OF SUFFICIENT PREDICTIVE VALUE TO JUSTIFY THEIR POTENTIAL ABUSE. ASSAULT, WHICH IS ONE POTENTIAL EXCLUSION CATEGORY, COULD OFTEN INVOLVE CIRCUMSTANCES SUCH AS BARROOM BRAWLING THAT MAY RELATE AS MUCH TO ADOLESCENT MATURATION OR SOCIAL PRACTICE AS ANY TEMPERAMENTAL LIKELIHOOD TO ABUSE PATIENTS. IT IS A CASE BY CASE QUESTION. FELONY AS A CATEGORY IS VIRTUALLY IRRELEVANT, GIVEN THE WIDESPREAD PRACTICE OF MISDEMEANOR PLEAS AND VARIATIONS IN CHARGING AND SENTENCING. SEXUAL CRIMES AND CERTAIN DRUG CHARGES ARE PROBABLY AT LEAST AS IMPORTANT AS ASSAULT. IF THERE IS TO BE A MANDATORY EXCLUSION, IT SHOULD BE BASED ON SOME SPECIFIC STANDARD OF A CRIME RELEVANT TO THE DUTIES PERFORMED IN THE NURSING HOME.

P. 13, FRAUD UNIT TESTIMONY

THE TYPE OF RECORD CHECK IS CRUCIAL. THE ONLY CHECK THAT HAS ANY SIGNIFICANT RELIABILITY IS A FINGERPRINT CHECK. THERE IS ALSO THE QUESTION OF WHETHER IT STOPS AT ONE STATE OR GOES INTO THE NATIONAL FBI SYSTEM. THE WIDER THE NET, THE MORE SIGNIFICANT THE COST AND ADMINISTRATIVE BURDENS.

BUT OUR PRIMARY POINT IS THAT WHILE CRIMINAL RECORD CHECKS SEEM ON BALANCE TO BE DESIRABLE, SUCH REQUIREMENTS HAVE A SERIOUS LIKELIHOOD OF INDUCING A SENSE OF FALSE SECURITY. IN NEW YORK STATE, WHERE WE HAVE THE BEST DATA, AT BEST 2% OF ALL PATIENT ABUSE INCIDENTS END IN A CRIMINAL PROSECUTION. PAST PERFORMANCE IN NURSES AIDE OR OTHER HUMAN SERVICE POSITIONS IS THE MOST IMPORTANT THING TO HAVE. WE HAVE LONG BELIEVED THAT THE IDEAL SYSTEM WOULD BE ONE THAT TRACKS AN EMPLOYEE FROM POSITION TO POSITION. NURSING FACILITIES DO DISMISS EMPLOYEES THEY HAVE CONCLUDED HAVE BEEN DANGEROUS OR TROUBLESOME TO RESIDENT PATIENTS. ALL INDICATIONS ARE THAT MANY OF THESE INDIVIDUALS REMAIN IN THE INDUSTRY, A THREAT TO REPEAT THEIR UNSETTLING AND POTENTIALLY DANGEROUS HISTORY WITH THE NEXT EMPLOYER.

THE QUESTION IS HOW TO RELIABLY AND APPROPRIATELY TRACK THEM. THE HONEST ANSWER IS THERE IS NO EASY WAY. THE TWO GENERAL OPTIONS ARE TO PUT THE SCREENING BURDEN ON THE STATE, THROUGH A REGISTRY, OR TO PUT THE BURDEN ON EMPLOYERS, BY IMPOSING AN ACTIVE DUTY TO THOROUGHLY REVIEW AND SCREEN EMPLOYEE BACKGROUNDS.

p. 14, FRAUD UNIT TESTIMONY

THE LATTER IS CONCEPTUALLY SIMPLER AND WOULD AVOID IMPOSING ANOTHER ADMINISTRATIVE BURDEN THAT WE MAY NOT WISH THE STATES TO HAVE AT A TIME WHEN THIS LEGISLATION IS COMMITTING THEM TO SEVERAL YEARS OF UPGRADING MAJOR PORTIONS OF THEIR REGULATORY PROCESS. BUT MAKING IT AN EMPLOYER RESPONSIBILITY LEAVES US WITH TWO PROFOUND DIFFICULTIES: EMPOYERS HAVE NO RELIABLE WAY AT PRESENT OF IDENTIFYING A POTENTIAL EMPLOYEE WHO IS FALSIFYING HIS EMPLOYMENT HISTORY, AND COURT DECISIONS ARE MAKING EMPLOYERS INCREASINGLY RETICENT ABOUT COMMENTING ON THE PERFORMANCE OF FORMER EMPLOYEES.

THESE DIFFICULTIES LEAD US TO PROPOSE THE FOLLOWING AS AN ATTEMPT TO BEGIN TO PROVIDE MORE ACCURATE BACKGROUND INFORMATION ON NON-PROFESSIONAL NURSE AIDE EMPLOYEES, BUT TO DO SO BY PROCEEDING PRAGMATICALLY AND INCREMENTALLY. WE SUGGEST THIS COMMITTEE CONSIDER REQUIRING A STATE REGISTRY, AND THAT ITS ESTABLISHMENT BE COUPLED WITH A PATIENT ABUSE REPORTING REQUIREMENT, WHEREBY EVERY NURSING FACILITY MUST FILE A PROMPT REPORT TO STATE SURVEYORS OF ANY PATIENT ABUSE INCIDENT, WHETHER MISTREATMENT OR NEGLECT, FOR ALL EMPLOYEES, NOT JUST NURSES AIDES, FOR IMMEDIATE INVESTIGATION AND ADMINISTRATIVE SANCTION AS APPROPRIATE. IN ANY INSTANCE IN WHICH AN AIDE, OR OTHER EMPLOYEE, WAS SANCTIONED, IT WOULD BE REPORTED TO THE REGISTRY, WHO WOULD MAKE SUCH INFORMATION AVAILABLE TO EMPLOYERS.

IF THE COMMITTEE FOUND IT DESIRABLE, THE REGISTRY COULD ALSO SERVE OTHER FUNCTIONS. FOR EXAMPLE, IF CRIMINAL RECORD CHECKS ARE DEEMED DESIRABLE, IT WOULD PROBABLY MAKE THE MOST SENSE TO RUN THEM THROUGH THE REGISTRY, WITH A REQUIREMENT OF REPORTING BACK ONLY THOSE ITEMS THAT MET SOME DEFINED SENSE OF RELEVANCE TO FUTURE DUTIES. THE REGISTRY COULD ALSO BE A CENTRAL CHECKPOINT FOR PROOF OF TRAINING. IT MAY EVEN MAKE SENSE, AS WE SUSPECT THAT THERE IS A LOT OF MOVEMENT OF AIDE PERSONNEL BETWEEN NURSING FACILITIES, HOME HEALTH AND DAY CARE, TO MAKE IT THE CORE OF A PERSONAL SERVICES PERSONNEL REGISTRY THAT WOULD PROVIDE COMMON INFORMATION FOR ALL.

TO INSURE PROVIDERS CONSCIENTIOUSLY USE THE REGISTRY, THIS LEGISLATION SHOULD IMPOSE ON THEM AN AFFIRMATIVE DUTY TO BOTH DILIGENTLY SCREEN AND, WE WOULD ADD, TO PROVIDE SUCH SUPERVISION, DIRECTION AND REVIEW OF EMPLOYEE PERFORMANCE AS WILL REASONABLY MINIMIZE THE RISK OF EMPLOYEE MISCONDUCT.

FINALLY, ALTHOUGH IT IS UNFORTUNATELY LESS FASHIONABLE THESE DAYS TO ACKNOWLEDGE THE ROOT CAUSES OF MUCH OF THE BEHAVIOR THAT OUR CRIMINAL AND SOCIAL SYSTEMS MUST ULTIMATELY DEAL WITH, A REAL ATTACK ON THE PROBLEM OF NURSING HOME PERSONNEL MISTREATING PATIENTS MUST ADDRESS THE PROBLEMS OF TURNOVER, UNDERPAY, AND LACK OF SUPERVISION AND PROFESSIONAL STATUS THAT LEAVES FACILITIES USING A LESS THAN OPTIMUM LABOR POOL.

p. 16, FRAUD UNIT TESTIMONY

WE STRONGLY SUPPORT THE PROVISIONS THAT LOOK TO ESTABLISH MORE FORMAL PROGRAMS OF INTERIM SANCTIONS. OUR UNITS CONCUR IN THE CONCLUSION THAT THE ALL OR NOTHING CHARACTER OF EXISTING SANCTIONS MAKE ADMINISTRATIVE AGENCIES RELUCTANT TO USE THEM.

AT THE SAME TIME, WE NEED TO APPROACH INTERIM SANCTIONS WITH A RECOGNITION THAT SOME OF THE DYNAMICS THAT MAKE ADMINISTRATIVE AGENCIES RELUCTANT TO USE EXISTING SANCTIONS WILL CONTINUE TO OPERATE IN THE FUTURE, PARTICULARLY IN THE COMMON SITUATION WHERE A STATE IS SHORT OF NURSING HOME BEDS AND THEREFORE LOATH TO CLOSE A FACILITY. THE RESULT IS A RELUCTANCE TO FINALLY CLOSE ON THE PROVIDER, PARTICULARLY IF HE PLEADS INADEQUATE FUNDS TO PROVIDE PROPER CARE QUALITY AND ASSERTS A WILLINGNESS TO UPGRADE IF THE STATE FINDS A WAY TO FUNNEL MORE REIMBURSEMENT TO HIS FACILITY.

THIS LEADS TO A BARGAINING PROCESS THAT OFTEN DETERIORATES TO A GAME OF ADMINISTRATIVE CHICKEN BETWEEN THE DUAL IMPULSE TO ENFORCE THE LAW AND SAVE THE BEDS. IN THAT DYNAMIC, EXPECTATIONS ABOUT THE IMPOSITION OF INTERIM SANCTIONS HAVE TO BE HONESTLY TEMPERED BY THE ACKNOWLEDGEMENT THAT IMPOSING FINES AND TERMINATING MEDICAID REIMBURSEMENT COULD BE PERCEIVED AS JUST ADDING TO THE FINANCIAL BURDEN ON THE FACILITY THAT THE STATE ADMINISTRATIVE AGENCY WILL PERCEIVE, RIGHTLY OR WRONGLY, IT MUST ULTIMATELY SOLVE TO KEEP THE FACILITY IN BUSINESS.

p. 17, FRAUD UNIT TESTIMONY

THERE ARE TWO WAYS TO DEAL WITH IT. FROM AN ENFORCEMENT POINT OF VIEW, FINANCIAL SANCTIONS WORK BEST IF THEY ARE ROUTINELY APPLIED IN AS NON-DISCRETIONAY A FASHION AS POSSIBLE. AN UNMISTAKEABLE COMMITMENT BY THE STATE TO APPLY THEM ROUTINELY AND CONSISTENTLY, A FURTHER COMMITMENT TO CALL WHAT WE BELIEVE IS LARGELY THE BLUFF OF OPERATORS THREATENING TO ABANDON THE INDUSTRY AS A RESULT OF INSUPPORTABLE FINANCIAL BURDENS, WOULD, IN OUR OPINION, WORK. BUT IF THE STATE GETS INTO A LONG DRAWN OUT PROCESS, IF THE STATE LEAVES THE CONTROL OF THE FACILITY IN THE HANDS OF THE OPERATOR, HE WILL SEEK TO BARGAIN WITH THE STATE, TO MOBILIZE POLITICAL SUPPORT FOR A COMPROMISE OF HIS DEFICIENCIES, TO DO AS LITTLE AS HE CAN AS CHEAPLY AS HE CAN, AND TO RUTHLESSLY EXPLOIT THE CONCERNS ABOUT LACK OF BEDS FOR HIS OWN PURPOSES.

TEMPORARY MANAGEMENT, OR RECEIVERSHIP, AS PROPOSED BY THE COMMITTEE IS THE SECOND TOOL AND THE WAY OUT OF THIS DILEMMA FOR MORE TIMID STATES. BUT TO MAKE IT WORK, TO SET UP A HIERARCHY OF INTERIM SANCTIONS, WE STRONGLY RECOMMEND THAT THE PROVISIONS IN THIS LEGISLATION BE STRENGTHENED BY A REQUIREMENT THAT AFTER A CERTAIN PERIOD IT BECOMES AUTOMATIC.

p. 18, FRAUD UNIT TESTIMONY

WE ALSO RECOMMEND THAT ANY FACILITY IN WHICH THERE IS A RECEIVER BE REQUIRED TO PAY ALL THE COSTS OF PROVIDING THAT TEMPORARY MANAGEMENT. THE LEGISLATION SHOULD ALSO REQUIRE THE SECRETARY TO REQUIRE STATES TO SET UP STANDARDS FOR RECEIVERS AND TEMPORARY MANAGEMENT THAT GUARD AGAINST CONFLICT OF INTEREST, THAT INSURE MINIMUM QUALIFICATIONS AND ESTABLISH A POOL OF RECEIVERS THAT ARE READILY AVAILABLE FOR DEPLOYMENT.

WE ARE DELIGHTED TO SEE THE COMMITTEE PROPOSAL IDENTIFY THE PROBLEM OF REPEATED NON-COMPLIANCE. WE BELIEVE THE SECRETARY SHOULD BE DIRECTED TO DEVELOP STANDARDS FOR WHAT REPEATED NON-COMPLIANCE IS AND A FAR MORE AUTOMATIC RESPONSE IN ITS EVENT.

OUR UNITS HAVE HAD CONSIDERABLE EXPERIENCE WITH THE PROBLEM OF PATIENT RESTRAINTS. WE BELIEVE THE PROHIBITION AGAINST RESTRAINTS SHOULD BE TIGHTENED. THE STATUTE SHOULD PROVIDE THAT RESTRAINTS MAY ONLY BE USED FOR THE PHYSICAL SAFETY OF THE PATIENT OR OTHERS, SOLELY UPON THE WRITTEN ORDER OF PHYSICIAN THAT SPECIFIES BOTH A LIMITED LENGTH OF TIME AND THE EXACT CIRCUMSTANCES OF THEIR USE.

P. 19, FRAUD UNIT TESTIMONY

THE ARTICULATION OF PATIENT RIGHTS SHOULD INCLUDE LANGUAGE STATING PATIENT RIGHTS INCLUDE BUT ARE NOT LIMITED TO THOSE ENUMERATED. AS DISCUSSED ABOVE, THE LIST OF ENUMERATED RIGHTS SHOULD BE EXPANDED TO IDENTIFY A RIGHT OF RESIDENCE. WE ALSO BELIEVE IT WOULD BE HELPFUL IF IT WERE RECOGNIZED THAT PATIENTS HAVE A RIGHT TO BE INFORMED OF THEIR RIGHTS. A SEEMINGLY SMALL STEP, IT COULD HAVE A VITAL IMPACT IN SETTING A TONE. WE ARE CONCERNED ABOUT LANGUAGE THAT SUGGESTS A PATIENT HAS A RIGHT TO BE CONSULTED ON HIS TREATMENT, WHERE APPROPRIATE. IT SEEMS TO US THAT COULD BE READ TO WEAKEN THE TRADITIONAL RIGHT OF PATIENTS TO COMPLETE AUTHORITY OVER THEIR OWN MEDICAL TREATMENT.

THE PROVISIONS DEALING WITH ADJUDICATED INCOMPETENTS ARE NOT A REALISTIC ANSWER TO THE PROBLEMS OF DECISION-MAKING FOR INDIVIDUALS WITH IMPAIRED CAPACITY. ADJUDICATION OF INCOMPETENTS IN NURSING HOMES IS LARGELY LIMITED TO INSTANCES IN WHICH THERE ARE FINANCIAL FUNDS AT STAKE. WE RECOMMEND THAT PROVISIONS IN OTHER AREAS OF MEDICAL CARE FOR DEALING WITH PATIENT DECISION MAKING IN THE EVENT OF IMPAIRED ABILITY TO EXERCISE ONE'S OWN RIGHTS SHOULD BE IMPORTED INTO NURSING HOMES. IN SPECIFIC, WE RECOMMEND THAT UPON TIME OF ENTRY INTO THE FACILITY, THE PATIENT DESIGNATE IN WRITING A POTENTIAL SURROGATE FOR INSTANCES WHERE THEY ARE UNABLE TO MAKE DECISIONS ABOUT CONSENT TO TREATMENT, FINANCIAL MANAGEMENT, TRANSFER AND THE EXERCISE OF OTHER RIGHTS.

IN THE EVENT THE PATIENT HAS NO SUCH PERSON AVAILABLE, IT MAY BE DESIRABLE TO PERMIT HIM TO DESIGNATE HIS OWN PHYSICIAN, IF HE IS INDEPENDENTLY CHOSEN AND NOT PROVIDED BY THE FACILITY, OR THE STATE OMBUDSMAN TO ACT ON HIS BEHALF.

MOST NURSING HOME PATIENTS FORTUNATE ENOUGH TO HAVE A FAMILY TIE GENERALLY HAVE ONE PERSON WHO TAKES THE LEAD ON MAINTAINING HIS CONTACT WITH THE OUTSIDE WORLD AND COORDINATING SUCH ASSISTANCE AS HE NEEDS WITH HIS AFFAIRS. THAT IS THE CONTACT THAT WE SHOULD SEEK AS SURROGATE. MOREOVER, SUCH A DESIGNATED CONTACT WOULD SERVE ANOTHER IMPORTANT PURPOSE AS WELL, IN THE AREA OF TRANSFER RIGHTS. THAT DESIGNATED CONTACT SHOULD ALSO BE ADDED TO THE LIST OF THOSE NOTIFIED OF PENDING TRANSFER DECISIONS. IN MANY INSTANCES, THAT PERSON WILL DO THE REAL DEALING WITH THEIR CONSEQUENCES AND WILL UNDERSTAND, IN A WAY A PATIENT, EVEN A COMPETENT PATIENT MAY NOT, WHAT THE IMPLICATIONS OF BED HOLD POLICY ARE AND BE MOTIVATED TO GUARD THE PATIENT'S INTERESTS.

WE ARE CONCERNED THAT THE REQUIREMENT FOR USING THE DSM-3 AS THE INSTRUMENT FOR DEFINING MENTAL ILLNESS IS GOING TO RESULT IN A SIGNIFICANT PORTION, IF NOT A MAJORITY, OF NURSING HOME PATIENTS BEING DEFINED AS MENTALLY ILL, PLACING AN ENORMOUS UNINTENDED BURDEN ON NURSING HOMES AND THEIR REGULATORS AND LEADING TO A MASSIVE EXERCISE IN PAPER COMPLIANCE.

P. 21, FRAUD UNIT TESTIMONY

IS IT REALLY THE PURPOSE OF THIS LEGISLATION TO DEFINE EVERYONE WITH SOME DEFICIT IN MENTAL FUNCTIONING AS A RESULT OF THE PHYSICAL CONSEQUENCES OF AGING AS MENTALLY ILL OR MENTALLY RETARDED? WE DOUBT IT. BUT SINCE THE DSM-3 INCLUDES SUCH A WIDE RANGE OF MENTAL MIS-FUNCTION, FROM ALTZHEIMER'S DISEASE TO ALCOHOLISM, THAT IS A VERY POSSIBLE RESULT. MOREOVER, WHILE WE DO NOT HAVE ACCESS TO SYSTEMATIC DATA ON THE MEDICAL CHARTS OF NURSING HOME PATIENTS, WE HAVE ENCOUNTERED NUMEROUS INSTANCES WHERE DIAGNOSES SUCH AS ORGANIC BRAIN SYNDROME OR ORGANIC MENTAL SYNDROME ENCOMPASS THE VAST PORTION OF A FACILITY'S PATIENTS.

WE UNDERSTAND THE PURPOSE OF THESE PROVISIONS TO BE TO TIGHTEN UP AND GUARANTEE TREATMENT FOR MENTAL ILLNESS. WE THINK HOW THIS WILL FUNCTION NEEDS CAREFUL EXAMINATION.

WE ARE CONCERNED THAT THE LANGUAGE PERMITTING INVOLUNTARY TRANSFER FOR THE PATIENT'S WELFARE IS AN ENORMOUS POTENTIAL LOOPHOLE. WE SUGGEST IT BE EITHER TIGHTENED OR DROPPED.

THE LANGUAGE BANNING SOLICITING DONATIONS AS A CONDITION OF ADMISSION SHOULD BE ALTERED TO READ AS A CONDITION OF ADMISSION OR EXPEDITING ADMISSION. IN PRACTICE, EXPEDITING IS MORE COMMON. IN THE SAME PROVISION, INSTEAD OF A PERSON OR ORGANIZATION UNRELATED TO THE PATIENT, WE SUGGEST THE LANGUAGE READ NOT ACTING ON BEHALF OF THE PATIENT.

P. 22, FRAUD UNIT TESTIMONY

THE STANDARD SURVEY SHOULD INCLUDE FOR A SAMPLE OF HOMES A TEST OF THEIR PATIENT ASSET ACCOUNTS. UNACCEPTABLE CARE, NOT POOR CARE, AN OVERLY VAGUE PHRASE, SHOULD KICK IN THE EXTENDED SURVEY.

THE PROVISIONS AUTHORIZING ONSITE MONITORING OF COMPLIANCE ARE ONES WE HAVE LONG RECOMMENDED. WE ARE PLEASED TO SEE THE COMMITTEE ADOPT THEM.

IT IS CLEAR THAT THE INITIATIVE OF THIS COMMITTEE, RESPONDING TO LONG BUILDING CONCERNS OF PATIENTS, ADVOCACY ORGANIZATIONS AND ENLIGHTENED STATE OFFICIALS, MEANS THAT 1987 WILL BE AN IMPORTANT AND PROGRESSIVE YEAR FOR THE NURSING HOME INDUSTRY AND, ABOVE ALL, FOR THE HUNDREDS OF THOUSANDS OF PATIENTS WHO EACH YEAR LOOK TO THE INDUSTRY FOR HEALTH AND NURTURE. WE LOOK FORWARD TO A VIGOROUS AND EXTENDED DEBATE AS THE SPRING AND SUMMER PROCEED AS TO HOW BEST TO PROTECT THAT VITAL INTEREST, AND WE PLEDGE TO THIS COMMITTEE THAT OUR ASSOCIATION WILL MAKE EVERY EFFORT TO ASSIST AND PARTICIPATE IN THIS CRUCIAL EFFORT.

THANK YOU.

Mr. **Waxman**. I appreciate all that you've had to say, the three of you, and we look forward to working with you.

Let me ask you this one question. You heard the first two witnesses, I assume, this morning, who talked about what it was like for their mothers in Tennessee and Illinois.

Why do States tolerate such situations, and what can we do to encourage States to address such noncompliance promptly?

Do any of you want to respond to that? Mr. Johnson.

Mr. **Johnson**. Mr. Chairman, I agree that in the past States have been a little lax in this area to some extent. There have been, to my mind, a couple of reasons why this has been the case.

We have not had for a very long time this opportunity to apply intermediate sanctions. It's been a case where we shut off the money to the nursing home and move the patients out, or just shut off the money and find some other way to support the patients, and this does more damage to the nursing home than it does helping the facility, and the States are really reluctant to shut down nursing homes, that we need to find other ways, other places for the patients, and we haven't been able to do that as readily as we'd like.

The other is—the other problem that we had was—and we still have in some States is the business about certification and inspection of care. At least in our State, we have certification in my department, in Medicaid, and we have—I mean, inspection of care in my department, and certification is in another department.

We have situations where a nursing home can be certified to do business in the State of Georgia as a nursing home and yet have poor quality patient care, because the nursing home is living or operating at just the margin. If it drops just a little bit below, it doesn't take very much to bring it up, and it can bring it up and stay in compliance certification wise and still sometimes not be delivering the quality of care that the patients need.

With the new bill that this committee is working on, I believe that problem will be solved.

Mr. **Waxman**. Well, we hope to work with you, because we want the same thing, and that's good quality care for our elderly, particularly our low income elderly that are on the Medicaid program.

So you, all three of you, agree that the Federal Government asking for intermediate sanctions would be helpful?

Ms. **Marshall**. Yes.

Ms. **Saros**. Yes.

Mr. **Johnson**. Yes.

Mr. **Waxman**. Thank you very much. We appreciate your testimony.

We are being called to the House floor for another vote, so let's take a quick recess.

[Brief recess.]

Mr. **Waxman**. Each of the two witnesses appearing on the next panel represents several organizations concerned with the needs of the developmentally disabled and the mentally ill. Mr. Urbano Censoni is Deputy Director of the Bureau of Community Residential Services of the Michigan Department of Mental health. He is testifying today on behalf of the Consortium for Citizens with Developmental Disabilities, an umbrella group of some 16 organizations that work on behalf of the developmentally disabled. Ms. Eleanor Kohn is a volunteer with the National Mental Health Association. She is here today representing seven national mental health groups.

Thank you for being with us today. We're pleased to have you. Your prepared statements will be in the record, and would like to ask, if you would, to summarize in no more than 5 minutes.

Mr. Censoni, why don't we start with you.

## STATEMENTS OF URBANO CENSONI, ON BEHALF OF CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES; AND ELEANOR KOHN, ON BEHALF OF AMERICAN PSYCHOLOGY ASSOCIATION, MENTAL HEALTH LAW PROJECT, NATIONAL ALLIANCE FOR THE MENTALLY ILL, NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS, NATIONAL MENTAL HEALTH ASSOCIATION, ACCOMPANIED BY JOSEPH MANES (MHLP)

Mr. CENSONI. Thank you very much for having us. Let me also mention, Mr. Chairman, that I am the Chairman of the Governmental Affairs Committee of the State Mental Retardation Program Directors that represents the 50 States and the territories. The directors are in charge of programs for persons with mental retardation and developmental disabilities in those States.

Although my testimony will focus on issues related to people with disabilities, let me just say at the offset, that as a group, both the consortium and the State directors, that we really wish to be supportive and helpful in terms of reform in nursing home care for all people, no matter what their secondary disability might be.

And that we clearly commend the subcommittee for its efforts in doing so. And also, for helping us to really forge a National policy to eliminate inappropriate use of nursing homes for all people, whether they have disability or not.

Indeed, we see those sections of the bill as quite literally being a bill of rights for persons with disabilities or persons who are labeled mentally ill, who currently and appropriately reside or one day might in fact end up in a nursing home were it not for this legislation.

We find ourselves in almost an unusual position here in that, as you may well know, the Health Care Financing Administration has issued a position on who can be in a nursing home, certain disabilities that they feel cannot be or should not be in nursing home. They issued a guideline in August 1986; the guideline states in part: "Only a small percentage of mentally retarded persons can be appropriately cared for in general nursing homes."

I think it's noteworthy that, like many other issues, here we have a situation where parties at the State, at the national level, at the advocacy level really concur on the ethical and programmatic issues. The question remains, how will this policy be implemented?

Again, as you indicated, our written testimony is part of the record, I won't repeat it here. I want to highlight, however, three specific concerns that we have that we think need more attention.

Given the different programmatic needs of the two populations, we think that the bill should specify that the Secretary issue separate admission and screening criteria for persons labeled mentally ill, and those persons with disabilities.

We also believe that the bill should require the Secretary to publish proposed criteria no later than April 1988, provide for a 30- or 60-day review and comment, and issue the final criteria no later than October 1, 1988.

Hopefully, the Health Care Financing Administration will seek input from interested and knowledgeable groups before they issue proposed criteria, and, of course, the consortium and the State directors stand ready to help in any way possible with that.

Finally, really the promise of a better future for people in nursing homes whether they have a disability or not, really kind of rings hollow with that adequate financing; and I think you've touched on that, and testimony has touched on that a number of times today.

We're hopeful that the language in the bill as currently stated won't lead to a decision on the part of Health Care Financing Administration one day, that you really meant to say, that all program improvements whether they be in the nursing home, whether they be active treatment, whether they be community placement options, would be financed exclusively at State costs.

To the contrary, by definition, the reason for the bill, the reason for all this testimony is indicative that people with disabilities and appropriately placed in nursing homes really have been under financed for many years. States and the Federal Government, in effect, have saved millions of dollars every year at the expense of disabled people.

We need to forge a cooperative venture, a policy here that really maintains the partnership, the Federal, State partnership around entitlements at current matching formulas.

To exclude Federal participation just invites further deterioration in services; it will not improve opportunities for the people that we're all concerned about.

In fact, we plead, if I could use that term, with the subcommittee to consider language that would provide waiver type services for this population, utilizing the appropriate setting, the place where these folks, perhaps, should have been all along. For example, in ICF/MR as the cost comparison in determining the State and Federal financial participation.

Finally, let me say that as I thought about writing this verbal part of my testimony that the only thing I regret is that the many people I have met in all my visits to nursing homes couldn't be here today, the people who really are anxiously awaiting this legislation, who are eager, desperate to get out of nursing homes.

And again, we thank the subcommittee for taking this bold step, and we hope that you will take the three or four additional steps that we think are required to really meet our mutual objectives of improving the quality of life of people in nursing homes.

Thank you.

[Testimony resumes on p. 473.]
[The prepared statement of Mr. Censoni follows:]

## STATEMENT OF
## CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

### I. INTRODUCTION

My name is Urbano Censoni. I am the Deputy Director of the Bureau of Community Residential Services, Program Development, Policy and Standards within the Michigan Department of Mental Health. In that capacity, I oversee the Department's efforts to design and implement services for persons with mental illness and developmental disabilities across the State. I also serve as Chairman of the Governmental Affairs Committee of the National Association of State Mental Retardation Program Directors.

Today, I appear before the Subcommittee as a representative of the Task Force on Medicaid Long Term Care of the Consortium for Citizens with Developmental Disabilities. The Consortium represents some 50 national organizations interested in the welfare of children and adults with severe, chronic disabilities originating in childhood. Many of the organizations that are affiliated with the Coalition, including the signatories of this statement, are acutely aware of the impact which the federal-state Medical Assistance program has on the capability of the states and private providers to furnish appropriate, high quality services to Title XIX-eligible children and adults with developmental disabilities.

We commend the Subcommittee for its efforts to upgrade the quality of care provided to persons residing in Medicaid-certified nursing homes. As the 1986 report of the

Institute of Medicine reminds us,[1] the individuals who live in these facilities are among the most vulnerable citizens in American society and, therefore, constant vigilance is required if they are to receive the scope and quality of services they are entitled to under federal law.

On May 5, Chairman Dingell introduced the "Medicaid Nursing Home Quality Care Amendments of 1987" (H.R. 2270), with many members of this Subcommittee listed as co-sponsors of the legislation. The bill is designed to implement the key recommendations of the Institute of Medicine study. My testimony today will concentrate on just one aspect of the bill -- the provisions dealing with pre-admission screening and appropriate placement of persons with developmental disabilities and mental illness.

Since these provisions of the bill are not addressed in the IOM study, I would like to take a few minutes to outline the nature of the problem before commenting on the proposed legislative solution.

## II. BACKGROUND

A. Scope of the Problem. National estimates vary regarding the number of persons with developmental disabilities who are residents of general-purpose nursing homes

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[1] Committee on Nursing Home Regulation, Institute of Medicine, Improving the Quality of Care in Nursing Home, National Academy Press: Washington, 1986.

(i.e., ICFs and SNFs). The 1977 National Nursing Home Survey concluded that there were an estimated 80,000 persons with a primary or secondary diagnosis of mental retardation living in such facilities. However, a special analysis of these data revealed that about 42 percent of this identified subpopulation of nursing home residents were 63 years of age or older. Based on this analysis, the staff of the Center for Residential and Community Services at the University of Minnesota concluded that it would be more realistic to focus attention on the 42,400 nursing home residents with a *primary* diagnosis of mental retardation, of whom approximately one-third (32%) were 63 years of age or older. The CRCS staff added that, "...especially for the middle-aged and younger mentally retarded people, the frequent lack of habilitatively oriented programs and contact with age peers have led to concern about the appropriateness of nursing homes as residential alternatives".[2]

National data on persons with developmental disabilities other than mental retardation is not available at the present time. We can report, however, that the number of persons with a primary diagnosis of cerebral palsy or other severe physical impairments appears to be quite high, based on the findings of studies conducted in a few states.[3]

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[2] Lakin, K. Charlie, Bradley Hill and Robert Bruininks, *An Analysis of Medicaid's Intermediate Care Facility for the Mentally Retarded (ICF/MR) Program*. Minneapolis: University of Minnesota, Department of Educational Psychology, 1985, pp. 4-10 and 11.

Several years ago, officials of the Health Care Financing Administration became concerned about the heavy concentration of non-elderly persons with developmental disabilities who were residing in general-purpose nursing homes, particularly in Illinois and Indiana. HCFA began to pressure officials in these states to take steps to assure that active treatment services were being provided to all persons who needed and could benefit from an individualized program of developmental training. The sequence of events that occurred in Indiana and Illinois provide valuable insights into the nature of the current problem:

- In 1984, the Indiana General Assembly amended the state health code to require that all persons with developmental disabilities be reviewed by a specially constituted, multi-disciplinary screening team prior to admission to any health facility (including any Medicaid-certified nursing home). All admissions of persons with developmental disabilities to SNF and ICF facilities now are based strictly on the individual's medical needs and geriatric status, rather than the nature and/or severity of his/her developmental disabilities.

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[3] For example, a recent review of persons with developmental disabilities in Illinois nursing homes found that 9 percent of the 2,864 persons assessed had a primary diagnosis of cerebral palsy, while an additional 8 percent had a secondary or tertiary diagnosis of CP (see further discussion and citation below).

Follow-up legislation, requiring the State Department of Public Welfare (the single state Medicaid agency), in cooperation with the Department of Mental Health, to complete a comprehensive assessment of the service needs of all nursing home residents with developmental disabilities, was enacted by the General Assembly in 1985. In carrying out this legislative mandate, Indiana officials identified 2,377 residents of ICF facilities with developmental disabilities who were under 65 years of age and had no primary medical conditions. Of this number, the assessment data indicated, at least 1,782 (or 75%) appeared to be appropriate candidates for transfer to small, community-based ICF/MR facilities or other family-oriented settings. An additional 910 nursing home residents with developmental disabilities -- all of whom are known to either be elderly or have medical conditions -- are scheduled to be assessed this fiscal year.

Meanwhile, based on the results of the preliminary assessment data, DPW and DMH last year submitted to the Chicago Regional Office of HCFA a five year plan for moving inappropriately placed nursing home residents to alternative residential settings. The plan calls for reducing the number of ICF residents with developmental disabilities from 2,681 in FY 1985 to 847 in FY 1991. Most of these individuals will be relocated in specialized community ICF/MR facilities, foster family homes or semi-independent living settings.[4]

- Under pressure from the Chicago Regional Office of HCFA, the Illinois Department of Public Aid (the single state Medicaid agency), the Department of Mental Health and Developmental Disabilities and the Governor's Planning Council on Developmental Disabilities recently completed a comprehensive assessment of the needs of persons with developmental disabilities who are residing in general ICF facilities. Based on assessment data from 328 nursing homes (housing a total of 2,864 persons with developmental disabilities), this study[5] concluded that:

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[4] Indiana Department of Public Welfare and the Indiana Department of Mental Health, Indiana's Plan for Development of Appropriate Residential Programs for Developmentally Disabled Persons, August 1, 1986.

- only ten percent of the total number of individuals assessed were appropriately placed in ICF facilities;
- only 26 percent of the individuals requiring developmental training were receiving such services;
- the most appropriate placement for a majority (70 percent) of the affected population is an ICF/DD facility, where they have access to both developmental training and medical support services; and
- 20 percent were recommended for transfer to a specialized residential facility without medical support services (e.g., a small ICF/DD-certified community residence).

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[5] Taylor Institute, "Evaluation and Services Identification Project for Developmentally Disabled Residents of Intermediate Care and Skilled Nursing Facilities: A Report Prepared for the Illinois Department of Public Aid and the Governor's Planning Council on Developmental Disabilities", February, 1987.

> DPA and DMHDD are currently working on a multi-year plan to ensure that the affected nursing home residents receive the services they require in the most appropriate residential setting.

I should hasten to add that the problem of inappropriate nursing home placements appears to be distributed unevenly across the country. Observers in a number of states report that they have few, if any, non-elderly persons with developmental disabilities living in nursing homes. Where the problem does exist, however, it can pose a major barrier to the delivery of effective residential and support services for such persons.

The State of Michigan has a multi-year strategy for reducing the number of persons with developmental disabilities living in nursing homes. One key component of this plan is to totally eliminate the placement of children in nursing homes and virtually eliminate the admission of adults to such facilities. The other critical element is an aggressive placement process. As a result of efforts to date, the number of nursing home residents with developmental disabilities has been cut from 1,400 to 640 since 1979.

Although we intend to continue to identify alternative residential settings for nursing home residents with developmental disabilities, fiscal constraints currently threaten our capability of achieving the goal of eliminating all inappropriate placements. In an attempt to address this problem, Michigan recently submitted a Medicaid home and community-based waiver request to HCFA. Our waiver request includes projected placements of nursing home residents with developmental disabilities. While the average per capita cost of community-based services for these individuals will be higher than comparable nursing home costs, the difference will be more than offset by ICF/MR placements and deflections. The net result will be substantially lower aggregate expenditures for both the federal government and the State of Michigan over the three year waiver period.

B. HCFA's Response. In response to growing public concern regarding the number of persons with developmental disabilities living in nursing homes, last year HCFA officials issued an administrative guideline which outlines the specific conditions under which such individuals may be served appropriately in SNF and ICF-certified facilities.[6] This August, 1986 guideline emphasizes that "only a small percentage of mentally retarded persons" can be appropriately cared for in general nursing homes. To qualify for SNF-level care an individual with mental retardation must require "...skilled medical care on an in-patient basis that cannot be provided in an ICF/MR..." or another alternative setting. However, even if the needs of such an individual are primarily medical in nature, his or her developmental needs still must be addressed by the facility "...to the extent allowed by the individual's overall physical condition." HCFA anticipates that, in most cases where SNF care is required, mentally retarded residents "...will not generally be well enough to receive a typical program of... developmental training, especially if it is provided outside the facility." The facility in these instances still must "...aggressively pursue those areas of intervention needed." Individuals who are "...well enough to attend outside training," the guideline stresses, "nearly always will be well enough to be placed in an ICF/MR or other appropriate setting."

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[6] Section 4395, State Medicaid Manual, HCFA Transmittal No. 19, dated August, 1986

In reviewing the appropriateness of continued care in an SNF facility, state inspection of care (IOC) teams will be expected to "...determine whether the services available in the facility promote the [mentally retarded] patient's maximum physical, mental and psychosocial functioning;" if the individual is not receiving such services, a negative IOC finding is warranted.

Persons with mental retardation may be appropriately placed in ICF-certified facilities if they are "of advanced age", institutional care is required and the individual can no longer benefit from developmental training. Such decisions, however, "...must be made on an individual basis rather than at an arbitrary age because some elderly retarded persons benefit greatly from continued developmental services".

More recently, the General Accounting Office has issued a report on nursing home care for persons with developmental disabilities in three New England states.[7] The authors of the report conclude that HCFA needs to do more to assure that such persons are appropriately placed and receive the services they require.

It should be obvious from the foregoing discussion that: (a) there are literally tens of thousands of persons with developmental disabilities currently residing in general purpose nursing homes who have limited, if any, access to habilitative services and live in an environment where they have little opportunity for peer relationships and age-appropriate activities; and (b) federal and state policymakers can no longer ignore the waste of human potential associated with the current situation. With these thoughts in mind, we will turn next to an examination of the relevant provisions of H.R. 2270.

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[7] General Accounting Office, Medicaid: Addressing the Needs of Mentally Retarded Nursing Home Residents. Washington: GAO/HRD 87-77, dated April, 1987.

## III. PROVISIONS OF THE BILL

A. Pre-Admission Screening. After January 1, 1989, H.R. 2270 would prohibit the admission of any person with mental retardation or mental illness to a Medicaid-certified nursing facility unless the appropriate state agency had: (a) certified that the individual needed the level of services provided by a nursing facility; and (b) determined whether the individual required "active treatment" services. After this date, federal financial participation would not be available on behalf of any individual with mental illness or mental retardation who was admitted to a nursing facility without his or her being screened prior to admission. By October 1, 1988, the Secretary of Health and Human Services would be obligated to establish minimum criteria for conducting pre-admission screenings and reviews of persons with mental retardation and mental illness who were applicants for, or residing in, a nursing facility.

Given the large number of individuals with mental retardation and mental illness who have been placed inappropriately in general-purpose nursing homes, CCDD strongly supports a statutory requirement that all such persons be screened, using criteria promulgated by HHS, prior to being admitted to any Medicaid-certified nursing facility. We also agree that responsibility for conducting such screening programs and making clinical judgements regarding the service needs of persons with mental retardation and mental illness should rest with the state agency (or agencies) with expertise in serving such persons, and not with the single state Medicaid agency.

The language of Section 1921(g)(6) of the bill should be amended, however, to: (a) require the Secretary to publish separate criteria governing admissions and continued stays by persons with mental illness and mental retardation (and related conditions); and (b) permit public comments on those proposed criteria prior to final promulgation.

Since the underlying causes and treatment goals of persons with mental illness are usually quite different from those of individuals with developmental disabilities, the factors which must be taken into account in determining the appropriateness of nursing home care also will be different. As a result, the Secretary should be directed to issue separate criteria applicable to these two major disability categories. In order to allow the interested public to have a voice in the development of such criteria, the Secretary should be required to publish proposed criteria no later than April 1, 1988, allowing thirty (30) days for public comments. Final criteria would have to be issued no later than October 1, 1988, as specified in the language of the current bill.

B. Services to Inappropriately Placed Nursing Home Residents. Effective April 1, 1990, a state would be obligated to review every resident of a nursing facility with mental illness and/or mental retardation to determine whether the individual requires: (a) the level of services provided by a nursing facility; (b) the level of services provided in another type of institution; and (c) active treatment services. These reviews would have to be repeated at least annually thereafter, with the federal government assuming 75 percent of the cost of conducting such reviews.

If a nursing home resident with mental illness or mental retardation was determined, as the result of such a review, to need the level of services provided by a nursing facility and required active treatment, the state would be obligated to provide, or arrange for the provision, of active treatment services, at state expense. If nursing home services were not required but the individual needed active treatment, the state would have to provide, or arrange for the provision, of active treatment services, at state expense. In the latter case, if the affected individual had been residing in a nursing facility for 30 months (2½ years) or more, the state would have to give him or her the choice of remaining in that facility or receiving such services elsewhere; if the individual elected to remain in the nursing facility, federal financial participation would continue to be available on the individual's behalf, even though he or she did not require the level of services provided by the facility; in such instances the state would be required to provide or procure active treatment services for such individuals. If, however, the affected individual had not been residing in the nursing facility for at least 30 months, the state would have to arrange for his/her safe and orderly discharge and provide, or arrange for the provision of, active treatment services following discharge, at state expense. Finally, if the state determined that a nursing home resident with mental illness or mental retardation did not require either the level of services provided by a nursing facility or active treatment, the state would be obligated to arrange for the safe and orderly discharge of the individual from the facility.

It is not clear to us why the sponsors of H.R. 2270 elected to propose such restrictions on FFP, but we suspect that it is an attempt to keep this aspect of the legislation "cost neutral". Unfortunately, the effect of this short-sighted policy would be to relegate such persons to the very same facilities where they have been ill-served in the past, with little hope that their developmental service needs would be addressed adequately. Remember, the people we are talking about were shunted off to nursing homes during earlier efforts to depopulate state mental hospitals and institutions for persons with mental retardation. For the past ten to twenty years, most of them have received little in the way of developmental services, while their peers who remain in state-operated facilities or were placed into community residences of various sorts have been given access to an increasingly sophisticated array of habilitative services. Millions of federal and state dollars have been "saved" at the expense of these individuals and now the bill asks that they be sacrificed, once again, in the interest of "cost neutrality".

CCDD believes that it is time for Congress to ensure that this frequently over-looked portion of the nursing home population has access to the same range and quality of services available to similarly situated persons in our society. Indeed if there is any group in this Nation that is more entitled to compensation for past societal neglect, I would be hard-pressed to identify it.

CCDD wholeheartedly supports a statutory requirement that the service needs of each existing nursing home resident with mental retardation (and related conditions) or mental illness be reviewed to determine whether he or she could be served more appropriately in an alternate setting. However, we wish to voice our STRONG OPPOSITION to the provision of the bill dealing with persons who are found to need active treatment or services provided by a facility other than a Medicaid-certified nursing home. These provisions, in our opinion, would exacerbate the current situation, leaving existing nursing home residents with mental retardation (and related conditions and mental illness even more vulnerable than they are at the present time.

If the states are denied federal financial participation (FFP) in the cost of active treatment for current nursing home residents with mental retardation (and related conditions) and mental illness who are found to be in need of such services, they will face overwhelming fiscal disincentives to transferring such persons to alternative residential settings, despite evidence that the great majority of such individuals could benefit greatly from transfers. [Note, for example, the results of the Indiana and Illinois assessments summarized above.] This disincentive effect would be particularly powerful in the case of long term nursing home residents (i.e., those who have resided in a nursing facility for 30 months or more), since the bill would authorize continued FFP on behalf of an individual who remained in a nursing home, even though the individual did not require the level of services provided by the facility.

Not only would the state lose FFP, but the individual resident would be denied access to Mediciad-reimbursable services that he or she otherwise would be entitled to receive. The inevitable result would be a discriminatory application of Medicaid entitlements. A state, for example, would be authorized to claim full Medicaid reimbursement for active treatment services delivered to any eligible resident of an ICF/MR facility, except for an individual transferred from a nursing home because he or she was determined to need active treatment services that could be furnished most effectively and efficiently in an ICF/MR-certified facility. Similarly, if a former nursing home resident needed active treatment services and met ICF/MR level of care requirements but was found to be capable of benefitting from alternative home or community-based services, the state would not be entitled to claim FFP for such services on his or her behalf, despite the fact that the same individual would qualify for federal reimbursement if he had previously resided in an ICF/MR and was participating in an approved home and community-based waiver program.

Obviously, the present provisions of the bill are likely to result in numerous perversities and distortions in policy which would work to the detriment of existing nursing home residents with mental illness, mental retardation and related conditions. They also run counter to the goal of maximizing the potential of persons with developmental disabilities through increased opportunities for independence, productivity and integration, as articulated by Congress in the Developmental Disabilities and Bill of Rights Act Amendments of 1984 (P.L. 98-527).

To correct these defects, CCDD recommends that the following modifications be made in Section 1921(f)(4)(c) of H.R. 2270:

1. Require each state, effective July 1, 1990, to certify that every individual with mental illness or mental retardation or a related condition (as defined by the Secretary) who is a resident of a nursing facility is receiving appropriate services from, or through, the facility.

2. For any such individual who is NOT receiving appropriate services, the state should be obligated to submit a plan to the Secretary, no later than July 1, 1990, outlining the steps that will be taken to:

   a. Provide appropriate developmental training services, as specified in each individual's plan of care, for all such persons who REQUIRE the services provided by a nursing facility;

   b. Transfer all such persons who do NOT REQUIRE the types of services provided by a nursing facility but, nonetheless, need active treatment to either: (1) another Medicaid-certified facility with the capability of meeting his/her service needs; or (2) alternative non-institutional services of comparable quality available under the state's Medicaid plan; and

c. Take any interim steps necessary to assure that active treatment services are furnished to all individuals who: (1) meet the criteria of (b) above; and (2) are awaiting transfer to another, more appropriate facility or program.

3. All transfers and service enhancements called for under the state's plan (as required under item 2 above) would have to be completed no later than July 1, 1992. After this date, FFP would be withheld on behalf of all individuals with mental illness or mental retardation (and related conditions) who were residing in nursing facilities and receiving inappropriate services, as determined in accordance with Secretarially-established review criteria.

The substitute approach outlined above would afford inappropriately served nursing home residents much greater assurance that they would be relocated to more appropriate service settings or receive the necessary mix of medical supports and developmental training while remaining in a Medicaid-certified nursing facility. In addition, it would allow the states adequate time to complete the facility transfers and program improvements necessary to ensure that all current nursing home residents with mental illness and mental retardation (and related conditions) have access to the full range of required services. As the experiences of Indiana and Illinois illustrate, states with a relatively large number of inappropriately placed nursing home residents will be unable to develop and implement programmatically sound alternatives within the timeframes allowed under the current bill. The events which led states to place large numbers of persons with mental retardation and related conditions into nursing homes during the late 1960's and early 1970's offer an instructive lesson in the pitfalls of hastily conceived and poorly executed placement programs. The additional two years called for in CCDD's recommendation, we believe, would strike a balance between the need for prompt state action and the logistical problems associated with developing hundreds, or in some states thousands, of alternative residential and day programming opportunities for former nursing home residents.

Finally, CCDD objects strenuously to the implication that only long term nursing home residents (i.e., those who have resided in such a facility for 30 months or more) should have a voice in choosing among available residential alternatives. We recommend that this provision be deleted and, instead, the transfer rights of nursing home residents with mental illness and mental retardation (and related conditions) be linked explicitly to Section 1921(c)(2) of the bill. It is particularly important that all such persons have access to the mental health or developmental disabilities protection and advocacy systems within the states, since frequently they lack the capacity to represent their own interests and may not have family members or friends to represent them.

## IV. OTHER RELATED ISSUES

As the findings of the Illinois and Indiana assessments tend to illustrate, there are a significant number of nursing home residents with mental retardation and related conditions who do not need the services of a nursing facility and could benefit from transfer to a community-based residential program. Almost all of these individuals (with a few rare exceptions) meet the criteria for admission to an ICF/MR facility and will require an ongoing, individualized regimen of habilitative services. Indeed, if they were residing in an ICF/MR facility, they would be considered prime candidates for home and community care waiver services, provided in accordance with Section 1915(c) of the Social Security Act.

However, states currently face a significant barrier to qualifying such individuals for waiver services, ironically because of the very fact that they reside in ICF or SNF-certified nursing homes. In most states, payment levels to such facilities are so low that state officials are unable to justify the cost effectiveness of alternative community-based services, since the average per capita cost of community services would exceed the average per capita cost of nursing home care for the affected population. Nursing home rates are lower, of course, because these residents do not have access to the full array of habilitation services they need and otherwise would be entitled to receive if they were residing in an ICF/MR or participating in an approved Section 1915(c) waiver program. In other words, due entirely to HCFA's regulatory formula for calculating the cost effectiveness of waiver services, these nursing home residents cannot qualify for such services.

For example, Illinois has attempted to use its Section 1915(c) waiver program as a vehicle for serving nursing home residents with developmental disabilities who could benefit from community-based services. These efforts, however, have been largely frustrated by the fact that current nursing home payment rates are less than half the average per capita cost of an appropriate array of residential and day services for such individuals. Consequently, the State intends to transfer the vast majority of these 3,200 individuals to ICF/DD-certified community residences. The net result will be higher per capita service costs than would be the case under the waiver program and less individualized residential and day programming alternatives for this population.

To correct this problem, CCDD recommends that the Subcommittee develop legislation which would allow states to use the average per capita cost of ICF/MR services in calculating the cost-effectiveness of HCB waiver services for persons who: (a) are developmentally disabled; (b) currently reside in a Medicaid-certified nursing home (i.e., a nursing facility as defined in the bill); and (c) meet the state's ICF/MR level of care criteria, based on an individualized assessment conducted in accordance with Section 1915(c)(2)(B).

The proposed amendment would not increase the number of persons potentially eligible for waiver services under current law, since all of the affected individuals would be residing in Medicaid-certified long term care facilities at the time they were considered for admission to the waiver program. Nor would it result in any long term increase in the total cost of Medicaid services, since, under the terms of the bill, states would be forced to either transfer persons inappropriately placed in general nursing homes to ICF/MR facilities or enhance the existing facility's capability of furnishing such services (by, no doubt, increasing the facility's per diem or separately vendorizing such services). Indeed, to the extent that community-based services prove to be less costly than institutional forms of care (as has generally been the case under MR/DD waiver programs to date), the proposed amendment may result in lower average costs, systemwide, for long term care services.

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In summary, CCDD congratulates the Subcommittee on addressing the subject of inappropriate nursing home placements in the present bill. At the same time, we strongly urge the Subcommittee to reconsider the discriminatory manner in which FFP would be denied for services on behalf of such persons.

I appreciate this opportunity to share with you the Consortium's view regarding H.R. 2270 and hope that you will feel free to call on us if we can offer further advice or assistance when you begin to mark up this important legislation.

Mr. **Waxman**. Thank you very much.
Ms. Kohn.

### STATEMENT OF ELEANOR KOHN

Mrs. **Kohn**. I'm Mrs. Eleanor Kohn, and I'm here from Danbury, CT. Sitting on my right is Mr. Joe Manes from the Mental Health Law Project; I asked Joe to accompany me. I hope you would ask me some difficult questions, and I'm going to turn them over to him for answers.

I'm a trained social worker who many years ago decided to use my training as a volunteer in the mental health field, and in so doing I've been working at State, local and National level with the Mental Health Association, with the American Hospital Association. I've been a member of the President's Commission on Mental Health, and the National Institute of Mental Health Advisory Council.

I'm here today, as you've mentioned, representing seven other groups including the Mental Health Association. But these credentials I think fade by comparison in my testimony today. I would rather tell you that I am a daily visitor at a nursing home where my mother, my elderly mother is a patient. I am also of a family which has been through the trauma of losing a family member at a very young age to Alzheimer's. I know what it's like to be a family care giver.

You have copies of our testimony. I think you'll find, as you read it, that it indicates our general support for H.R. 2270. It's a good bill. And frankly, a committee that can produce a bill that gets the OK from seven different groups, I think deserves congratulation.

I'd like to explain our support today, and maybe call attention to a problem area that we think still remains.

We're especially pleased with your recognition of the fact that the needs of nursing home patients who also have mental illnesses are unique and may in many ways differ from the rest of the nursing home population. That kind of recognition is long overdue, and very necessary when you look at statistics, because almost two-thirds of all nursing home patients, residents, have mental disability diagnosis. And of that population the incidence of mental illness is significantly greater for those under 55 than for those over 55. And I think that's an important point, too. We tend to consider nursing home residents as the very elderly. That is not true of the mentally disabled.

Also, that younger group have diagnoses that are much more amenable to the kind of treatment that can be made available in the community, the psycho-social kinds of treatment. They are more amenable to active treatment rather than custodial care. And for that reason, we think it is most important that the question of appropriateness of placement of these mentally ill people has to be raised.

It's obvious that there has been a dumping of patients with mental illnesses into nursing homes. I asked around the State of Connecticut and discovered that one region, where they have identified 1,020 nursing home beds, tell me that 300 of those beds are filled with State hospital discharges, directly out of the State hospital and into the nursing home. Many of those people don't need the kind of intense level of physical care that they're getting in those nursing homes. And many of them are not getting the kind of mental health care that they can really use.

It's absolutely urgent that there be prescreening for admission; that there be evaluation; that we have some kind of appropriate psychiatric and psychological counseling. And most of all, that there be adequate staff training. This is the exception rather than the rule in most nursing homes.

Let me tell you a little bit about this elderly mother of mine, because I think that has something to do with what we're here for today. She underwent some serious surgery which put her into a post-surgical psychosis, nursing home care was necessary. She was admitted to what I think is a good nursing home with a caring staff.

She was agitated, she was confused. Her general practitioner who also was a caring physician prescribed psychotropic drugs for her. She developed increasingly more agitation. She was put into restraints. She became extremely confused. They went back to the general practitioner, he prescribed more drugs. She became lethargic. She really moved out of the world of the living.

I finally demanded psychiatric consultation. The psychiatrist came in, took her off these drugs, took her out of the restraints. She is now up and around and dressed and functioning, and told me in no uncertain terms that she wished I would take a sabbatical from this volunteer work down in Washington so I could stay around there and take care of her. She's back in the world of the living.

We're encouraging and supporting your provision for looking at the psychotrop—the use of psychotropic drugs and the use of restraints, both chemical and physical with patients.

We are very pleased, and hope you will continue to hold on to the preadmission screening and resident review provision. We think that can have positive impact, not only for the patients but for health care costs, because that may well keep patients out of hospitals.

We like your active treatment provision. Our one objection in this bill is the objection that has been raised by the speaker before and that is the withdraw of Federal participation in the cost of active treatment. We're asking you to look at that again. We think that, even in those States which are now reimbursing for active treatment, if that Federal participation is withdrawn, the whole active treatment concept will be lost.

I'm going back to a home where, I'm not sure who I feel sorrier for, the residents who are constantly calling for attention, which they're not always getting, or the staff who are closing their ears to those calls because they don't have the tools, they don't have the training, and they don't have the backup to respond appropriately to the needs of the patients.

I appreciate what you're doing here in this committee to make changes in that kind of situation.

Thank you.

[Testimony resumes on p. 489.]

[The prepared statement of Mrs. Kohn follows:]

## STATEMENT OF ELEANOR KOHN

Mr. Chairman, I am Eleanor Kohn of Danbury, Connecticut. I am a social worker by profession and have been a volunteer for the mental health association for 34 years. I was a member of the Research Task Panel of the President's Committee on Mental Health and I am now on the governing council of the Psychiatric Section of the American Health Association. I also have been a member of the Executive Board of the National Mental Health Association.

Perhaps I can offer first hand insights into the problems faced by nursing home residents since I am a daily visitor at a skilled nursing facility where my mother is being care for. I have also been through five years of trauma with a brother who died from Alzheimer's and am keenly aware of the problems faced by care givers.

In addition to the National Mental Health Association, I am appearing before the subcommittee on behalf of several national organizations representing mental health concerns: Mental Health Law Project, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers, National Alliance for the Mentally Ill, National Association of Protection and Advocacy Systems and the American Psychological Association.

The groups I represent are pleased to endorse the purpose of HR 2270 and commend you, Chairman Dingell, and the members of your subcommittee for taking a leadership role to put into statute the basic recommendations of last year's Institute on Medicine Report, "Improving the Quality of Care in Nursing Homes."

HR 2270 is a good bill. It is apparent that substantial thought and effort went into its creation. And we can testify that your staff, Mr. Chairman, genuinely sought the views of mental health groups throughout the bill's development. We are pleased that, unlike the nursing home reform bill you introduced last year (HR 5450), the bill we are examining today addresses the problems and needs of current nursing home residents with mentally disorders and those with diagnosed mental conditions who are at risk of nursing home placement. We generally endorse HR 2270.

Unfortunately, we have serious problems with the bill's failure to authorize Medicaid reimbursement for the cost of active treatment for nursing home residents with mental disorders. My testimony will articulate our misgivings as well as offer alternatives to the provisions in the bill.

Before turning to the bill's provisions, it is important for the subcommittee to understand the extent to which residents with mental disorders comprise the nursing home population.

## BACKGROUND INFORMATION

It is clear from the National Nursing Home Survey published in 1977 and a 1981 NIMH report that nursing homes have become the major institutional setting for the care of individuals with mental disorders, exceeding the number in state mental institutions. (National Center for Health Statistics. National Nursing Home Survey: 1977 Summary (D/HEW Pub. No. 79-1794), 1979 and U.S. D/HHS Care of the Mentally Ill in Nursing Homes.

Addendum to the National Plan for the Chronically Mentally Ill (DHHS Pub. 81-1077), 1981).

The statistics that follow, drawn from the NNHS survey, are approximations. But they offer a broad indication of the magnitude of the problem:

* 668,000 nursing home residents (about half of the 1.3 million nursing home residents) have a primary or secondary diagnosis of mental disorder.

- Of this total, 72,000 have chronic mental disorders without physical disorders; 35,000 have both physical and mental diagnoses; 21,000 suffer from senility with accompanying psychosis.

- Another 561,000 residents are senile, almost three quarters of whom also have physical disorders. (Existing policy guidelines issued by the Health Care Financing Administration state that senility is not considered a mental illness for purposes of classifying a facility as an institution for mental dieseases (IMD). Senility, however, is often treatable and reversible. Residents diagnosed as "senile" need to have the full range of services available to them to meet their physical, mental and psychosocial needs. In the light of the progressive elements in HR 2270, we recommend that the subcommittee re-examine the IMD definition as it applies to nursing facilities.)

* Typically, residents with mental disorders are younger than those with physical problems. In 1977, more than 90 percent of the physically ill nursing home population were age 65 or over, but only about half of the mentally disabled population were in this age group. (Goldman, Feder and Scanlon. "Chronic Mental

Patients in Nursing Homes: Re-examining Data From the National Nursing Home Survey," Hospital and Community Psychiatry, March 1986, pp. 269-272.)

* About one-fourth of mentally disabled residents, compared with one-tenth of physically disabled residents, do not need the help of another person in the activities of daily living. Residents with mental disorders are also less likely to be fully dependent (18 percent) -- that is, to need assistance in all activities of daily living including toileting and eating -- than residents with physical disorders (45 percent). (ibid. Goldman).

Preliminary data available from the 1985 National Nursing Home Survey shows that the 1977 patterns have not changed substanially. Almost two-thirds of the nursing home population (981,000 people) have a mental disorder diagnosis. Of the population under age 55, 70% have a mental disorder while of those over 55, 45% have such a diagnosis. Thus, individuals with mental disorders represent a significantly greater proportion of younger nursing home residents.

This latest data also show that the most prevalent types of mental disorders differ significantly between the younger and older populations. Younger nursing home residents more often have mentally illnesses for which treatment and community services can be effective. In the younger population, 30% have a diagnosis of schizophrenia, 21% a diagnosis of depressive disorder, 21% anxiety disorders and 10% alcoholism. All of these are disorders for which active treatment and rehabilitation services can be effective. This data suggests that a high percentage of individuals under age 55 who are now in nursing homes would be better placed in alternative community settings.

In contrast, in the population over age 55, the most prevalent mental disorder is dementia (70% have dementia such as Alheizmer's disease). In contrast, only 21% of those with mental disorders who are under age 55 have diagnosis of dementia. (Unpublished data from the 1985 NNHS provided by NIMH).

## INADEQUATE MENTAL HEALTH CARE IN NURSING HOMES

Many of us as advocates for the mentally ill promoted and supported the policy of deinstitutionalization designed to move people from custodial care in state and county mental hospitals into active treatment in less restrictive and more humane community settings. To our chagrin, the policy often resulted in "transinstitutionalization" with tens of thousands of long-stay psychiatric patients transferred to nursing homes and other custodial care settings. A review by NIMH found that 40 percent of patients aged 65 and over discharged from state and county mental hospitals in 1969 were initially referred to nursing homes. (NIMH, 1971).

Nursing homes have become the primary focus of long term care for people with mental disorders, yet many of them do not belong there, and for those who do, specialized services are generally non-existent or at best inadequate. Several studies reveal the seriousness of the problem.

According to a 1981 study commissioned by the National Center for Health Services Research, nursing homes, for the most part, do not have special programs or services for the mentally disabled, nor do such facilities regularly employ trained mental health staff. The study found that nursing home environments tend to be restrictive and do not permit individuals to gain the skills necessary for independence. Many mental disabilities remain undiagnosed in nursing homes and plans of care do not include considerations for the individual's psychological level of functioning. Nursing homes often rely solely on medication to control disruptive behavior. (Denver Research Institute "Factors Influencing Deinstitutionalization of the Mentally Ill: A Review and Analysis," DHHS, National Center for Health Services Research, April 1981)

A General Accounting Office study in 1982 found that although nursing homes have become frequent health care providers for the elderly with mental health problems, the treatment provided remains almost exclusively focused on physical illnesses so that mental conditions remain undiagnosed and untreated. As a result, the GAO found, mentally disabled nursing home residents have limited prospects for improvement. (U.S. General Accounting Office, "The Elderly Remain in Need of Mental Health Services," HRD-82-112, September 1982)

The study for the National Center for Health Services Research concludes that many mentally disabled people in nursing homes are inappropriately placed. Many residents (20-40 percent in some studies) are receiving more intensive care than necessary and in general residents receive too few rehabilitation services of any kind. Nursing home residents suffer because of the lack of trained staff members and because they have limited contact with consulting health and mental health professionals.

Furthermore, residents have little privacy and inadequate attention is given to developing their independence and responsibility for self-care. (Denver Research Institute)

Another study conducted through the Illinois Department of Mental Health and Developmental Disabilities found that care in nursing homes is primarily custodial in nature, that there is evidence of inappropriate medication and that the number of mental health services a patient receives is small. Furthermore, the longer a patients stays in the nursing home, the less service the patient receives. As a result, for patients who remain in the facility for more than one year, symptomatology worsens on personal neatness and psychomotor retardation, both of which could result from the deleterious effect of being in an institution. The study concludes that nursing homes are serving "primarily custodial care functions in the mental health system. Little rehabilitative treatment is provided and little rehabilitative outcome is accomplished." (Bootzin, Richard and William Shadish, Jr., "Evaluation of Mental Health Long-Term Care Facilities," January 1983, Illinois Department of Mental Health and Developmental Disabilities -- Grant #908-13 and 8209-21.)

The 1982 GAO study reported that mental conditions often remain undiagnosed because nursing homes are not equipped and have little incentive to provide mental health diagnosis or treatment. Left undiagnosed and untreated, nursing home residents with mental disorders have limited prospects for improvement and their overall conditions may decline more rapidly and ultimately place greater demands on the health care system.

I would like now to turn to the provisions of the bill. My testimony will concentrate on three provisions of HR 2270 of major significance to residents who are mentally ill: (1) psychotropic drug control; (2) pre-admission screening and resident reviews, and; (3) active treatment.

## PROVISIONS OF THE BILL

### 1. Psychotropic Drugs

HR 2270 recognizes many of the special needs of nursing home residents with mental disorders. Of particular importance are the requirements relating to the use of psychotropic drugs. The bill requires that psychotropic drugs can be administered only on the orders of a physician and as part of a plan of care designed to eliminate or modify the symptoms for which the drugs are prescribed. Further, and most importantly, the nursing home is required to have an independent consultant in psychopharmacology review the appropriateness of drug regimen at least annually. (Section 1921(c)(1)(C).) In addition, the bill requires that each resident shall be "free from any...chemical restraint imposed for purposes of discipline or convenience." (Section 1921(c)(1)(A)(ii).)

The vital need for these provisions is highlighted by data from the 1984 National Nursing Home Study Pretest, which found that more than half the psychotropic prescriptions did not meet the criteria for appropriateness because they lacked a diagnosis or symptom in the resident's chart or were not the best drug for the condition described. Even when the choice of a drug was appropriately supported by a diagnosis, there were often prescribing problems, most commonly subtherapeutic dosages.

The data in the new NNHS study is the latest in a number of studies indicating that psychotropic medications are misused in nursing homes. Given the serous side effects of these medications, the findings are most worrisome.

Since the bulk of medical supervision in nursing homes is provided by primary care physicians, the periodic review of drug regimens by an independent consultant is especially appropriate. In fact, we would urge that all residents have their drug plans reviewed, not just those who are on psychotropics. But at a minimum, the provisions in the bill must be retained.

2. Preadmission Screening and Resident Reviews

Extensive data exists indicating that a substanial percentage of all nursing home residents are inappropriately placed and that the level of care offered by the nursing facility does not accurately meet their health care needs. Similarly, there is data demonstrating the prevalence of inappropriate placement of individuals with mental disorders into nursing homes.

- The state of Minnesota estimated that approximately 30 percent of all elderly persons in nursing homes could have avoided placement if sufficient community support were available. Another 10 to 20 percent of those already in nursing homes were suitable for community placement with extended services.

- A recent review of a random sample of 60 of 300 elderly patients at St. Elizabeths Hospital scheduled for transfer to nursing homes revealed only 10 to 20 percent were judged to have significant physical problems requiring interventions by professional or skilled staffs and that the percentage requiring assistance with activities of daily living varied form 11 percent (assistance with ambulation) to a high of 39 percent (assistance wit bathing). Based on these findings, the reviewers, part of a federal-court-appointed team of monitors, concluded that most of the patients require a less restrictive setting than a nursing home. They recommended the development of supervised group homes linked with needed health and social support services.

The Congressional Budget office, the most frequently cited source of data, concluded that after reviewing 14 studies that the level of care 10 to 20 percent of all patients in skilled nursing facilities (SNFs) and 20 to 40 percent in intermediate care facilities (ICFs) is higher than the residents need. (Congressional Budget Office, "Long Term Care for the Elderly and Disabled," Government Printing Office, 1977.) While the studies reviewed by CBO do not concentrate on residents who are mentally ill, one may conclude that since mentally disabled residents are younger, their potential for placement into the community is greater than the overall nursing home population.

So, we enthusiastically endorse the requirement in the bill that an appropriate state agency must screen all new admissions with a diagnosis of mental disorder to determine that the individual requires the level of services provided by a nursing facility. We would modify the requirement to require the state to determine the least restrictive setting available in which the mentally ill individual can receive the services he or she requires.

The Committee should be aware that the concept of preadmission screening is not a new one. A 1981 survey indicated that 22 states had statewide preadmission screening programs and that seven had programs that covered parts of the states. (Steiner and Needleman, "Expanding Long Term Care: Operations and Issues in State Program Design," prepared for the National Center for Health Services Research, 1981.) The programs are generally of two types: The most frequent approach is a "gatekeeper" mechanism that prevents public-pay patients from being admitted to an institution when admission is deemed inappropriate. The second type views preadmission screening as an integral part of a range of long-term care services, and uses community-based services wherever possible. The second model is becoming more important as states expand their coverage of home- and community-based services.

The preadmission screening requirement also builds upon an existing Medicaid state plan requirement in Section 1902(a)(44) that provides for physician certification "at the time of admission" to an SNF, ICF, general hospital or mental hospital "that such services are...required to be given on an inpatient basis because the individual needs...such services."

We also endorse the concept of periodic patient reviews of the continued need for the level of care provided by a nursing facility. As with preadmission screening, there is a basis for this requirement in the Medicaid statute. Section 1902(a)(31) mandates "a regular program of independent professional review" for each SNF and ICF patient which determines "(i) the adequacy of the services..., (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services...."

3. Active Treatment

We are pleased that HR 2270 mandates "active treatment" for nursing facility residents with mental disorders who need that level of care. As the Committee is aware, "active treatment" is not a new or novel concept in patient care. It is a requirement in Medicare for patients in psychiatric hospitals and psychiatric units of general hospitals. It is required by regulations for residents in intermediate care facilities for the mentally retarded (ICF/MR) in Medicaid. And, while the term "active treatment" is not used in the current regulations for skilled nursing facilities applicable to both Medicare and Medicaid, the concept clearly appears throughout the conditions of participation and standards.

Basically, "active treatment" means that the nursing home residents have a written plan of care based on a diagnostic evaluation by qualified mental health professionals. The plan of care contains an individualized program of therapies and services administered or supervised by mental health professionals. The goal of each plan of care is, at a minimum, to improve the individual's level of functioning or to improve the resident's mental condition so that nursing home care is no longer necessary.

However, while we endorse the requirement for "active treatment," we vigorously object to and strongly oppose the bill's failure to permit federal financial participation (FFP) in the cost of active treatment for residents with mental disorders who are apporpriately placed in a nursing facility. Requiring the state to pay the full cost of active treatment for these residents is a significant change in the Medicaid program. It represents a cut-back in the program. Those states that are now reimbursing for mental health care and those nursing homes that are actively treating their residents with mental disorders will stop doing so if they lose their federal matching for any care defined by the Secretary as "active treatment."

While we recognize that your committee is operating under budget restraints, the solution of requiring active treatment but not paying the cost is counter-productive. The provision will not hold up through final enactment; and when it falls, we fear it will take with it the entire preadmission screening and patient review section. The active treatment provision, with federal matching funds, is vitally important to ensure that individuals who are appropriately placed in nursing homes with diagnosed mental disorders receive the care that they need.

We recommend the following changes to HR 2270 relating to residents with mental disorders requiring active treatment:

- A definition of active treatment should be included in the statute.
- Active treatment for mental disorders should be part of the all-inclusive reimbursement rate paid to the nursing home facility for which FFP is available.
- The statute should provide for reimbursement levels which are based on the intensity of services needed by each resident.

- The nursing facility should be encouraged to contract for services with community-based mental health service providers; however, the responsibility for assuring the resident receives active treatment must rest with the nursing facility.

- States should be afforded greater authority to utilize the home and community-based waiver provisions in Section 1915 of the Social Security Act so that residents who do not require the level of care provided by a nursing facility, but who need active treatment, can be released from the nursing facility into community-based treatment programs.

- The nursing home should be required to contract with community-based case managers who will work towards the release of these residents.

## CONCLUSION

Thank you, Mr. Chairman, for the opportunity to provide you and your subcommittee on the special needs of nursing home residents with mental disorders. I know you will seriously consider our recommendations for improving HR 2270. We have tried to be conscious of the budgetary constraints within which you are operating. We are confident that our recommendations, while improving the quality of care, also contain cost offsets through the expanded use of community-based care settings.

Over the past two decades, since the enactment of Medicaid, we have seen many positive changes in the treatment of people with mental disorders resulting from research findings. Unfortunately, improved services have not generally found their way into nursing facilities. Congress has the opportunity in this bill to require that the special needs of nursing home residents with mental disorders are recognized and that the treatment they require is provided.

Mr. **Waxman**. Thank you very much. I thank both of you for excellent statements.

I would like to first comment on what may be a misunderstanding about H.R. 2270's provision concerning screening and review requirements for individuals with developmental disabilities or mental illness. We do not intend to deny Federal financial payment to States for active treatment services that are provided to individuals who leave a nursing facility for more appropriate care in another setting, so long as the individual is eligible for Medicaid, and so long as Medicaid covers that more appropriate care.

For example, if a nursing facility resident could be more appropriately cared for in an intermediate care facility for the mentally retarded, and the State arranges for his or her transfer to such an institution, the State would still be reimbursed for any covered services that are provided there if the individual is eligible for Medicaid.

The same would be true for a resident who would be more appropriately served through a Medicaid home and community based waiver program, as long as he or she qualifies for the program.

I hope this clarifies the confusion.

Mrs. **Kohn**. I think we understand that but one of the questions is what happens to the patient who is in the skilled nursing facility in need of active treatment which may if it is given to him, get him from that skilled nursing facility to a less intensive level of care? What about the Federal match there?

Mr. **Waxman**. If they are still eligible for Medicaid and it is a Medicaid covered service, he or she would still receive the Federal support for it.

Do you have any information to the contrary?

Mr. **Manes**. I'm just looking for the page that has it. My reading was that if the individual requires a level of care that a nursing home provides and is found to be in need of active treatment, that active treatment must be provided at the State's cost under the terms of the bill.

Mr. **Waxman**. Exclusive State cost?

Mr. **Manes**. Exclusive State cost.

Mr. **Waxman**. Is that because of the Medicaid laws?

Mr. **Manes**. No; because of this bill.

Mr. **Waxman**. We'll certainly check into it and see what the situation is and see if we can deal with it.

Both of you objected to the provisions of the bill that would require States to pay for active treatment services for those individuals who require such services, whether or not they need the level of care. I wish we could afford to match the State outlays for active treatment of this population and in situations other than ICF's for the mentally retarded. I just don't think we can talk about expanding the Medicaid coverage. If it is coverage that is already there, then I don't think we want to take it away. As much as I would like to expand coverage, given the kind of circumstances we have here in Washington today, I think it is unlikely we will be able to get that accomplished.

If there are no additional Federal dollars to help pay for the services, how else can we assure that the needs of these individuals will be met, and that the States won't simply dump them on the streets adding to the ranks of the homeless? Don't these provisions offer incentives to place these individuals in more appropriate settings to which Medicaid reimbursement may very well be available?

Do you have any comment?

Mr. **Censoni**. Perhaps two points, Mr. Chairman. I think your clarification is certainly helpful and let me just say that there was a summary of the bill that I believe led to some of this misunderstanding, where a State was identified as the payer for any improvement and perhaps that isn't the issue any more.

The other one is that undoubtedly as we move towards doing some of the things that are in the bill, certainly as a result of the bill it will be very helpful but even now States are moving in that direction. There will be circumstances—let me become parochial for a second.

A person with retardation in a nursing home where certainly an option for them would be to go to an ICF/MR. That ICF/MR is perhaps twice as expensive as the nursing home or perhaps even three times more expensive than the nursing home they are coming from.

We would prefer to see that person go into a community residence instead of the ICF/MR. Under a home and community based waiver, if the person were in the ICF/MR, we would be able to do a cost comparison to that ICF/MR level of care. If a person is in a nursing home, we have to use the nursing home's payment as the comparison.

You have had testimony here about $37 a day and $40 a day and $24 a day. It is literally impossible to provide adequate services, getting to your point, about let's not use this as a way of dumping people even to less responsible forms of care, so one of the things we have asked for the subcommittee to look at is the possibility that for those people who would qualify for other entitlement programs, that are more expensive than the ones they are in, they be used as the cost comparison for placement options instead of going to another institution.

Mr. **Waxman**. We will take a look at that.

Mrs. **Kohn**. I have another comment, too. Obviously we recognize the kind of budget constraints that you are operating under. I'm glad it is your job and not mine. A recent report that came out of the Congressional Budget Office points out that 10 to 20 percent of all patients in the skilled nursing facilities and 20 to 40 percent of patients in intermediate care facilities get higher levels of care than they need. For the mentally disabled patients, most of whom are younger, these figures are probably even higher, the figures in terms of the percentages.

There is money being utilized but not being utilized in the most effective fashion. I guess we are calling this to your attention in the hope that in the long run there may be some way to finding a more appropriate utilization of that kind of money.

Mr. **Waxman**. I appreciate those points and we will certainly see what we can do. We will continue to talk to each other and see what we can work out.

Mr. **Censoni**. Thank you. Again, we do applaud the bill.

Mr. **Waxman**. Thank you.

Our last panel represents organizations who do advocacy work on behalf of nursing home residents and have long been involved with issues concerning nursing home reform. These groups have played an essential role in identifying the need for quality improvements and persuading the Federal Government to take its responsibilities seriously.

Ms. Susan Rourke is with the Citizens for Better Care of Detroit and is testifying today on behalf of the National Citizens' Coalition for Nursing Home Reform. Ms. Marjory Blood is a member of the National Legislative Council of the American Association of Retired Persons.

I thank both of you for being here today. Ms. Blood, may we start with you?

## STATEMENTS OF MARJORY BLOOD, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS; AND SUSAN ROURKE, EXECUTIVE DIRECTOR, CITIZENS FOR BETTER CARE, AND NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Ms. Blood. Thank you. My name is Marjory Blood. I am a member of the AARP's National Legislative Council and the Maine Committee on Aging. I chair the Advisory Committee for Maine's Long Term Care Ombudsman Program. On behalf of the more than 25 million members of the American Association of Retired Persons, I want to thank you for this opportunity to State the association's views on the need to reform our Nation's nursing home quality assurance policies.

We also wish to commend you for leading the way by introducing H.R. 2270, which addresses almost all of our priority concerns.

The time for action has come for Congress and the administration to correct the deficiencies that persist in too many nursing homes today. AARP strongly endorses the position papers put together by the Coalition Campaign for Quality Care in Nursing Homes.

Our comments on nursing home quality will focus on four primary areas of concern; nurses aide training; nurse staffing; enforcement and equal access to quality care. First, our discussion on quality of care must begin with the fact that nurses aides deliver over 80 percent of the direct hands on care to nursing home residents. Unfortunately, the vast majority of these staff people receive minimum wages and are untrained and unskilled. Annual turnover rates in the field are approximately 100 percent.

AARP recommends that the Secretary of HHS be directed to develop training and testing programs for nurses aides with a minimum of 160 hours of initial training required and assure that all aides are competent to perform tasks to which they are assigned through regular performance review and regular inservice training.

A second primary concern is there simply are not enough nurses in nursing homes. Under current Federal standards, ICF residents can be left in the care of untrained nurses aides for 16 hours per day and an unsupervised LPN for the other 8 hours. This situation creates a potentially very dangerous environment for very frail, dependent and very old residents.

AARP recommends that both ICF's and SNF's be required to have a 24-hour, 7-day-a-week registered professional nurse on the staff because there are very important differences in education and training between RN's and LPN's.

Last year's bill, H.R. 5450, included such a provision on the 24-hour RN care. We strongly urge that a similar requirement be incorporated into H.R. 2270 with appropriate waivers and that the effective date of the provision be moved up by phasing in the requirement by facility bed size, beginning January 1, 1988.

Third, even if every quality assurance recommendation in the IOM report became law, they would be meaningless unless they could be enforced. Too often in the past deficiencies have been ignored by Federal and State authorities because their only recourse was termination from the program and there were no beds available for patients who would need to be transferred.

As the IOM Committee stated, inadequate enforcement is a major problem. AARP is very pleased that H.R. 2270 addresses this important issue, is supportive of this provision in the bill. We urge, however, that additional sanctions be considered and that a provision to ensure that States use their enforcement authority effectively be added to H.R. 2270 because too often, States that have had a sufficient range of sanctions available failed to use them properly.

Finally, AARP believes that nursing homes should be required to maintain identical policies and practices regarding admissions, transfers, discharge and Medicaid covered services for all individuals regardless of source of payment.

With regard to discrimination in admissions, AARP would ideally like to see such practices abolished, as H.R. 5450 would have done. Since this does not seem to be feasible at the present time, we support an interim compromise which would prohibit discrimination in admissions unless the proportion of Medicaid residents in the facility is equal to or greater than the average Medicaid nursing home census in the State. Similar fair share statutes seem to be working well in New Jersey and Ohio while New York State has recently proposed a similar plan. We strongly urge that such a provision be added to H.R. 2270.

According to our preliminary analysis of the 1982 California data, the change would not impair the financial viability of providers. The data revealed that providers who meet their responsibility to admit a fair share of Medicaid beneficiaries performed better than other providers with both higher and lower Medicaid census. Fair share is designed as facilities within 5 to 10 percent of the State Medicaid occupancy average of 60 percent.

Clearly, the proportion of Medicaid patients in the facility in California has almost nothing to do with financial performance.

Briefly, AARP also believes that the nursing home personal needs allowance should be increased to $35 with a cost of living adjustment and that States should be required to specify what their Medicaid program covers. As our written statement details, we are also concerned that standard surveys be no less rigorous than those presently being conducted and ICF residents not be forced out of the nursing home when the ICF/SNF distinction is eliminated.

We are grateful that this committee has chosen to address many of the problems with nursing home quality and we offer our resources and assistance in enacting the reform into law this year.

Thank you.

[Testimony resumes on p. 507.]

[The prepared statement of Ms. Blood follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Mr. Chairman. My name is Marjory Blood. I am a member of AARP's National Legislative Council and of the Maine Committee on Aging. I also chair the Advisory Committee for Maine's Long-Term Care Ombudsman Program. On behalf of the more than 25 million members of the American Association of Retired Persons, I want to thank you for this opportunity to state the Association's views on the need to reform our nation's nursing home quality assurance policies. Before I begin, however, I would like to express AARP's appreciation for the Committee's interest in addressing the quality of nursing home care, an issue of increasingly vital concern to millions of American citizens. We also wish to commend you for leading the way by introducing H.R. 2270, which addresses many of our priorities.

## Introduction

In March 1986, the Institute of Medicine (IOM) issued a 415-page report on "Improving the Quality of Care in Nursing Homes," the result of a two year independent study undertaken with the support of Congress. Seven major conclusions arose from the study:

1) Quality of care and quality of life in many nursing homes are not satisfactory.
2) More effective government regulation can substantially improve quality in nursing homes. A

STRONGER FEDERAL ROLE IS ESSENTIAL.

3) SPECIFIC IMPROVEMENTS ARE NEEDED IN THE REGULATORY SYSTEM.
4) THERE ARE OPPORTUNITIES TO IMPROVE QUALITY OF CARE IN NURSING HOMES THAT ARE INDEPENDENT OF CHANGES IN THE MEDICAID PAYMENT POLICIES OR BED SUPPLY.
5) REGULATION IS NECESSARY BUT NOT SUFFICIENT FOR HIGH QUALITY CARE.
6) A SYSTEM TO OBTAIN STANDARDIZED DATA ON RESIDENTS IS ESSENTIAL.
7) THE REGULATORY SYSTEM SHOULD BE DYNAMIC AND EVOLUTIONARY IN OUTLOOK.

AARP SUPPORTS THESE CONCLUSIONS AND BELIEVES THAT THEY PROVIDE THE BASIS FOR TAKING ACTION THIS YEAR TO IMPROVE THE QUALITY OF CARE IN NURSING HOMES THROUGH BOTH THE LEGISLATIVE AND REGULATORY PROCESSES. UNFORTUNATELY, NURSING HOME RESIDENTS, WHO ARE AN EXTREMELY VULNERABLE AND FRAIL POPULATION, CONTINUE TO RECEIVE POOR QUALITY CARE IN FAR TOO MANY LONG TERM CARE INSTITUTIONS.

THESE CONCERNS WERE REITERATED IN A MAY 1986 INVESTIGATION CONDUCTED OVER TWO YEARS BY THE SENATE SPECIAL COMMITTEE ON AGING. COMMITTEE CHAIRMAN JOHN HEINZ CONCLUDED: "THIS REPORT ESTABLISHES THAT OUR CURRENT SYSTEMS OF INSPECTION AND ENFORCEMENT ARE INCAPABLE OF ASSURING THAT RESIDENTS ACTUALLY RECEIVE THE HIGH QUALITY CARE THE LAW DEMANDS. CONGRESS MUST ACT TO EFFECTIVELY STRENGTHEN THESE SYSTEMS AND UNDERSCORE THE RIGHTS

OF PATIENTS TO APPROPRIATE, QUALITY CARE."

THE TIME HAS COME FOR CONGRESS AND THE ADMINISTRATION TO CORRECT THE DEFICIENCIES THAT PERSIST IN MANY NURSING HOMES TODAY. WE CAN NOT RELY ONLY UPON MARKET FORCES TO INFLUENCE NURSING HOME BEHAVIOR. AARP STRONGLY ENDORSES THE POSITION PAPERS PUT TOGETHER BY THE CAMPAIGN FOR QUALITY CARE IN NURSING HOMES AND IS PLEASED THAT MOST OF THESE RECOMMENDATIONS HAVE BEEN INCLUDED IN H.R. 2270. OUR COMMENTS ON NURSING HOME QUALITY WILL FOCUS ON FOUR PRIMARY AREAS OF CONCERN: NURSES AIDE TRAINING, NURSE STAFFING, ENFORCEMENT, AND EQUAL ACCESS TO QUALITY CARE. WE WILL THEN BRIEFLY DISCUSS SEVERAL OTHER ISSUES THAT NEED TO BE ADDRESSED.

## NURSES AIDE TRAINING STANDARDS

ANY DISCUSSION OF NURSING HOME QUALITY MUST BEGIN WITH CAREGIVERS. IN THE LONG TERM CARE INSTITUTION, NURSES AIDES DELIVER WELL OVER 80 PERCENT OF THE DIRECT HANDS-ON CARE TO RESIDENTS. UNFORTUNATELY, THE VAST MAJORITY OF THESE STAFF PEOPLE RECEIVE MINIMUM WAGES AND ARE COMPLETELY UNTRAINED AND UNSKILLED. EVEN MORE ALARMING, ANNUAL TURNOVER RATES IN THE FIELD ARE APPROXIMATELY 100 PERCENT. THE JOBS ARE CHARACTERIZED BY LOW PRESTIGE AND LITTLE REWARD. GOOD TRAINING AND COMPETENCY TESTING OF NURSES AIDES IS LIKELY TO BE THE AREA IN WHICH FEDERAL LEADERSHIP WILL HAVE THE GREATEST IMPACT. AARP IS VERY GRATEFUL THAT THIS PROBLEM IS ADDRESSED IN H.R. 2270.

Our most recent figures show that 20 states have some form of mandatory nurses aide training programs, with requirements for both classroom and clinical/practicum training. The state of Illinois, for example, is recognized as having an exemplary nurses aide training program. The IOM report strongly recommends that training of nurses aides prior to employment in the long term facility should be federally mandated. AARP recommends that the Secretary of HHS be directed to develop and test training and testing programs for nurses aides, with a minimum of 160 hours of training required, along with developing criteria for approving or disapproving training programs in institutions, including those within nursing homes. We urge that such a minimum training hour requirement be added to H.R. 2270. Nursing homes should be required to assure that all aides are competent to perform tasks to which they are assigned through regular performance review and regular in-service training. We also recommend that states set up systems to monitor and review aide turnover at nursing homes in order to encourage retention, and that research be conducted at the national level to reduce these extraordinarily high turnover rates.

## Nurse Staffing Requirements

Another primary concern is that there simply are not enough nurses in nursing homes. In intermediate care facilities (ICFs), for example, all that is required is that a Licensed Practical Nurse (LPN) be on the day shift seven days per week. Thus, under

CURRENT FEDERAL STANDARDS, ICF RESIDENTS CAN BE LEFT IN THE CARE OF UNTRAINED NURSES AIDES FOR 16 HOURS PER DAY, AND AN UNSUPERVISED LPN FOR THE OTHER 8 HOURS. WITHOUT QUESTION, THIS SITUATION CREATES A POTENTIALLY DANGEROUS ENVIRONMENT FOR THE MANY FRAIL, DEPENDENT, AND VERY OLD RESIDENTS THAT OCCUPY MOST ICFs.

STAFFING REQUIREMENTS FOR SKILLED NURSING FACILITIES (SNFs) ARE ONLY SOMEWHAT BETTER, AS THEY REQUIRE A REGISTERED NURSE (RN) TO BE ON DUTY FOR ONLY 8 HOURS PER DAY SEVEN DAYS A WEEK WITH AN LPN ON STAFF 24 HOURS EACH DAY. THE ICF/SNF DISTINCTION IS BASED ON THE ERRONEOUS ASSUMPTION THAT ICF RESIDENTS ARE HEALTHIER, LESS VULNERABLE TO LIFE-THREATENING EVENTS, AND NEED LESS CARE AND SUPERVISION THAN SNF RESIDENTS. WHEN ONE CONSIDERS THE MUCH SICKER RESIDENT POPULATION NOW ENTERING ICFs DUE TO REDUCED HOSPITAL LENGTHS OF STAY UNDER DRGs, SNF BED SHORTAGES, AND THE FACT THAT THE ICF/SNF DISTINCTION VARIES TREMENDOUSLY FROM STATE TO STATE (E.G. 94 PERCENT ICFs IN LOUISIANNA, 98 PERCENT SNFs IN FLORIDA), IT BECOMES EVEN MORE CLEAR THAT THE ICF STAFFING REQUIREMENTS MUST BE RAISED AT THE VERY LEAST TO THE LEVEL OF THE CURRENT SNF REQUIREMENTS.

AARP'S STRONG PREFERENCE, HOWEVER, WOULD BE TO REQUIRE BOTH ICFs AND SNFs TO HAVE 24 HOUR, SEVEN DAY A WEEK RNs ON STAFF. THERE ARE IMPORTANT DIFFERENCES IN EDUCATION AND TRAINING BETWEEN RNs AND LPNs. LPNs, WHO TYPICALLY RECEIVE AT LEAST 2 FEWER YEARS OF EDUCATION THAN RNs, DO NOT HAVE SUFFICIENT MANAGEMENT, DIAGNOSTIC, OR ASSESSMENT SKILLS TO MONITOR FLUCTUATING PHYSICAL

CONDITIONS OR TREAT THE SUDDEN ONSET OF EMERGENCY MEDICAL SITUATIONS. WE ALSO REJECT THE ASSUMPTION THAT CARE NEEDS INEVITABLY DIMINISH DURING EVENING AND NIGHT HOURS. THE VETERANS' ADMINISTRATION PROVIDES A MODEL FOR NURSE STAFFING REQUIREMENTS IN ITS 117 LONG-TERM CARE FACILITIES, WHICH REQUIRE RNs IN CHARGE OF EACH WARD, ON EACH SHIFT. LAST YEAR'S BILL, H.R. 5450, INCLUDED A PROVISION ON 24 HOUR RN CARE. WE STRONGLY URGE THAT A SIMILAR REQUIREMENT BE INCORPORATED INTO H.R. 2270, AND THAT THE EFFECTIVE DATE OF THE PROVISION BE MOVED UP BY PHASING IN THE REQUIREMENT ACCORDING TO FACILITY BED SIZE, BEGINNING JANUARY 1, 1988.

IN CALLING FOR 24 HOUR RN STAFFING IN ALL NURSING HOMES, WE ARE SENSITIVE TO THE FACT THAT SERIOUS SHORTAGES OF THESE SKILLED PROFESSIONALS EXIST IN MANY AREAS. AARP, THEREFORE, SUPPORTS A WAIVER FROM THE NURSE STAFFING REQUIREMENT FOR THOSE HOMES WHO ARE UNABLE TO HIRE AN RN DESPITE MAKING A GOOD FAITH EFFORT TO ATTAIN THEIR SERVICES BY OFFERING A COMPETITIVE WAGE AND BENEFIT PACKAGE. WE HOPE THAT BOTH CONGRESS AND THE ADMINISTRATION WILL UNDERTAKE EFFORTS TO ADDRESS THESE CRITICAL SHORTAGES, AND WE PLEDGE OUR ASSISTANCE IN SUPPORTING SUCH ENDEAVORS.

## ENFORCEMENT ISSUES

ANOTHER PRESSING PROBLEM IS THE INSUFFICIENT RANGE OF BOTH FEDERAL AND STATE SANCTIONS AVAILABLE TO ASSURE COMPLIANCE WITH STANDARDS OF CARE. UNLESS APPROPRIATE ENFORCEMENT MECHANISMS ARE available and used effectively, we run the risk of having chronically out of compliance providers continue to operate under public programs without strong incentives to improve quality. Even if every quality assurance recommendation in the IOM report became law, they would be meaningless unless they could be enforced. Too often in the past, deficiencies have been ignored by federal and state authorities because their only recourse was termination from the program and no beds were available for patients who would need to be transferred. Between 1981 and 1984, for example, only 156 out of more than 13,000 nursing homes had their certification terminated. Moreover, large numbers of substandard homes temporarily correct their deficiencies under a plan of correction and quickly lapse into noncompliance until the next survey is conducted. As the IOM committee stated: "Inadequate enforcement is a major problem." AARP is very pleased that H.R. 2270 addresses this important issue.

Probably the two most effective sanctions that all states should be required to have in place are civil or administrative fines and court appointed receivers. Currently, 31 states have authority to impose civil or administrative fines and approximately 4 out of 5 IOM survey respondents claim they are an effective intermediate sanction. When state officials were asked during the IOM study why certain sanctions were effective, the two most frequent responses were "affect income of provider" and "quick implementation". In response to a question concerning the obstacles to effective use of sanctions, the most commonly cited

OBSTACLE WAS DELAYS. IT IS GENERALLY ACCEPTED THAT CIVIL FINES ARE AMONG THE MOST EFFECTIVE OF THE INTERMEDIATE SANCTIONS BECAUSE THEY AFFECT THE INCOME OF A PROVIDER, CAN BE SWIFTLY ENFORCED, UNENCUMBERED BY LENGTHY LITIGATION DELAYS, AND CAN BE SENSITIVE TO THE SEVERITY OF THE PARTICULAR VIOLATION AND THE HISTORY OF THE FACILITY. BY RAISING THE PRICE FOR REPEATED VIOLATIONS OR MORE SERIOUS DEFICIENCIES, CIVIL FINES CAN INCREASE PRESSURE ON THE FACILITY TO MAKE FUNDAMENTAL FINANCIAL OR MANAGEMENT CHANGES. CIVIL FINES ARE ALSO THE MOST LOGICAL REMEDY FOR DEALING WITH ELEMENT LEVEL DEFICIENCIES.

COURT-APPOINTED RECEIVERS CAN ALSO BE A VERY EFFECTIVE ENFORCEMENT MECHANISM. 25 STATES CURRENTLY HAVE THIS REMEDY AVAILABLE AND 5 OUT OF 6 SURVEY RESPONDENTS BELIEVE THEM TO BE EFFECTIVE. RECEIVERSHIP IS PARTICULARLY IMPORTANT FOR USE AS A THREAT TO FACILITIES THAT HAVE FAILED TO RESPOND TO OTHER SANCTIONS AND AS A METHOD FOR PROVIDING FOR THE SAFE TRANSFER OF RESIDENTS FROM A FACILITY THAT IS CLOSING. RECEIVERSHIP ENABLES THE STATE TO FORCE A POOR QUALITY FACILITY TO UPGRADE ITS OPERATIONS DRAMATICALLY. IN THOSE INSTANCES WHERE OWNERS THREATEN TO "TAKE THE MONEY AND RUN" RATHER THAN COMPLY WITH STATE AND FEDERAL STANDARDS, RECEIVERSHIP PERMITS GRADUAL RELOCATION OF RESIDENTS, AT THE OWNER'S EXPENSE, IN ORDER NOT TO JEOPARDIZE RESIDENTS' HEALTH, SAFETY AND WELFARE.

OTHER ENFORCEMENT MECHANISIMS WHICH SHOULD BE PUT IN PLACE IN STATES AND NATIONALLY INCLUDE BANS ON NEW ADMISSIONS, APPOINTMENTS OF MONITORS, TARGETED PLANS OF CORRECTION, AND PRIVATE RIGHTS OF ACTION FOR MEDICARE AND MEDICAID BENEFICIARIES.

ADMISSIONS FREEZES ARE AN IMPORTANT TOOL FOR DEALING WITH FACILITIES CHRONICALLY OUT OF COMPLIANCE BECAUSE THEY DIRECTLY AFFECT PROVIDER REVENUES AND CAN TAKE EFFECT QUICKLY PENDING APPEAL. 31 STATES CURRENTLY HAVE THE AUTHORITY TO SUSPEND ALL NEW ADMISSIONS. 18 STATES MAY APPOINT MONITORS, WHO REMAIN IN THE FACILITY AFTER THE SURVEY HAS BEEN CONDUCTED IN ORDER TO OBSERVE FIRST-HAND CORRECTIVE ACTIONS AND COMPLIANCE STATUS ON A CONTINUING BASIS. TARGETED PLANS OF CORRECTION ALLOWS ENFORCEMENT AUTHORITIES TO SPECIFICALLY ARTICULATE WHAT MUST BE DONE TO COME IN COMPLIANCE, SUCH AS HIRING ADDITIONAL NURSING STAFF. FINALLY, A BENEFICIARY PRIVATE RIGHT OF ACTION COULD BE AN EXTREMELY EFFECTIVE REMEDY FOR USE BY THOSE INDIVIDUALS WHO ARE MOST KNOWLEDGEABLE ABOUT CONDITIONS WITHIN THE NURSING HOME AND WHO ARE MOST LIKELY TO SUFFER PERSONAL INJURY AS A RESULT OF SUBSTANDARD CARE. WE REALIZE THAT STATES MAY COME UP WITH OTHER FLEXIBLE ENFORCEMENT MECHANISIMS THAT WOULD SERVE THE PURPOSE OF THOSE DISCUSSED ABOVE.

IT IS ALSO IMPORTANT THAT THE FEDERAL GOVERNMENT MONITOR STATE AGENCY ACTIVITY IN THE ENFORCEMENT AREA THROUGH THE USE OF LOOK BEHIND AND VALIDATION SURVEYS, AND OTHER MONITORING MECHANISMS. TOO OFTEN, STATES THAT HAVE A SUFFICIENT RANGE OF SANCTIONS AVAILABLE FAIL TO USE THEM PROPERLY. WE URGE THAT A PROVISION TO ENSURE THAT STATES USE THEIR ENFORCEMENT AUTHORITY EFFECTIVELY BE ADDED TO H.R. 2270. FEDERAL AND STATE ACTIONS MUST BE CLOSELY COORDINATED AND FEDERAL FINANCIAL PARTICIPATION SHOULD NOT BE WITHDRAWN WHEN STATES ARE IN THE PROCESS OF TAKING ACTION

TO RETURN THE FACILITY TO COMPLIANCE.

## EQUAL ACCESS TO QUALITY CARE

AARP IS EXTREMELY CONCERNED THAT MEDICAID BENEFICIARIES DO NOT HAVE EQUAL ACCESS TO QUALITY CARE IN THE NURSING HOME SETTING. THE STRONG PROVIDER PREFERENCE FOR PRIVATE PAY RESIDENTS IS AN UNDISPUTED FACT. IN SOME STATES, PARTICULARLY IN THE SOUTHEAST, THIS MAY BE DUE IN PART TO LOW MEDICAID REIMBURSEMENT RATES. THERE IS CONSENSUS BETWEEN PROVIDERS AND CONSUMERS THAT FACILITIES SHOULD NOT DISCRIMINATE AGAINST MEDICAID RECIPIENTS IN THEIR TRANSFER OR DISCHARGE PRACTICES. THERE IS MUCH LESS CONSENSUS, HOWEVER, IN THE AREAS OF SERVICES AND ADMISSIONS.

AARP BELIEVES THAT FACILITIES SHOULD NOT BE TO PERMITTED TO DIFFERENTIATE BETWEEN MEDICAID AND PRIVATE PAY RESIDENTS WITH REGARD TO THE QUALITY OR EFFECTIVENESS OF MEDICAID COVERED ITEMS AND SERVICES. RESIDENTS SHOULD BE FREE TO PAY, HOWEVER, FOR ADDITIONAL SERVICES BEYOND THOSE REQUIRED UNDER THE MEDICAID PROGRAM.

WITH REGARD TO DISCRIMINATION IN ADMISSIONS ON THE BASIS OF SOURCE OR AMOUNT OF PAYMENT, AARP WOULD IDEALLY LIKE TO SEE ALL SUCH DISCRIMINATORY PRACTICES ABOLISHED, AS H.R. 5450 WOULD HAVE DONE. SINCE THIS DOES NOT SEEM TO BE FEASIBLE AT THE PRESENT TIME, WE SUPPORT AN INTERIM COMPROMISE WHICH WOULD PROHIBIT DISCRIMINATION IN ADMISSIONS UNLESS THE PROPORTION OF MEDICAID RESIDENTS IN THE FACILITY IS EQUAL TO OR GREATER THAN THE AVERAGE

Medicaid nursing home census in the state. Similar prohibitions seem to be working well in New Jersey and Ohio, while New York state has recently proposed a similar plan. We strongly urge that such a provision be added to H.R. 2270. According to our preliminary analysis of 1982 California data, contrary to the assertions of some groups, the change would not impair the financial viability of providers. The data reveal that providers who meet their responsibility to admit a fair share of Medicaid beneficiaries (those facilities within 5 to 10 percent of the state Medicaid occupancy average of 60 percent) performed better financially than other providers, with both a higher and lower Medicaid census. Accordingly, the proportion of Medicaid patients in a facility in California was shown to have very little to do with financial performance.

AARP also strongly urges the Congress to pass legislation this year to increase Medicaid nursing home residents' personal needs allowance (PNA) by $10 per resident per month, from $25 to $35, indexed by a cost of living adjustment. The PNA covers a wide range of expenses not paid for under Medicaid, such as clothing, newspapers and phone calls, and has not been increased since it was first authorized in 1972. The change would restore a small amount of dignity, independence and purchasing power to these indigent nursing home residents, most of whom where forced to give up all their income and assets, and to impoverish themselves as a result of the spend-down process. In order to ensure that

THE PNA IS NOT SPENT ON ITEMS OR SERVICES WHICH MEDICAID SHOULD BE COVERING, WE URGE THAT A PROVISION BE ADDED TO H.R. 2270 TO REQUIRE STATES TO SPECIFY WHAT THEIR MEDICAID PROGRAM COVERS AND HOW THEIR REIMBURSEMENT RATES ARE DETERMINED.

TWO ADDITIONAL CONCERNS WITH H.R. 2270 ARE THE ADEQUACY OF STANDARD SURVEYS AND THE ELIGIBILITY OF CERTAIN CURRENT ICF RESIDENTS AS THIS LEVEL OF CARE IS PHASED OUT. FIRST, AARP HAS BEEN GENERALLY PLEASED, WITH SOME EXCEPTIONS, WITH THE IMPROVEMENTS THAT HAVE BEEN MADE BY HHS OVER THE PAST YEAR IN MOVING TOWARDS A MORE OUTCOME-ORIENTED, PATIENT-BASED SURVEY PROCESS. WE HOPE THAT THE DEVELOPMENT OF THE TWO-STEP STANDARD AND EXTENDED SURVEY PROCESS DOES NOT WEAKEN THE PROGRESS THAT HAS BEEN MADE AND, THEREFORE, URGE THAT STANDARD SURVEYS BE NO LESS RIGOROUS THAN THE SURVEYS THAT ARE BEING CONDUCTED AT PRESENT. SECOND, AS THE ICF/SNF DISTINCTION IS ELIMINATED, WE ARE CONCERNED THAT CURRENT ICF RESIDENTS MAY NO LONGER BE ELIGIBLE FOR NURSING HOME CARE UNDER THE STRICTER SNF CRITERIA. WE HOPE THAT THE CONSOLIDATION WILL NOT RESULT IN WIDESPREAD TRANSFER TRAUMA, AND URGE THAT ASSURANCES BE PROVIDED SO THAT THIS VULNERABLE POPULATION IS NOT FORCED OUT OF THEIR CURRENT LIVING ENVIRONMENT.

WE ALSO SUPPORT LEGISLATION WHICH WOULD: REQUIRE NURSING HOMES TO HAVE AN RN CONDUCT A RESIDENT ASSESSMENT WHICH INCLUDES A FEDERAL MINIMUM DATA SET OF CORE ELEMENTS AND COMMON DEFINITIONS; ASSURE THAT ALL RESIDENTS HAVE ACCESS TO APPROPRIATE SOCIAL SERVICES AND MENTAL HEALTH SERVICES; REQUIRE PROVIDERS TO DISCLOSE REVENUE AND CHARGE INFORMATION; ENCOURAGE STATES TO

IMPLEMENT REIMBURSEMENT SYSTEMS WHICH REWARD HIGH QUALITY AND ARE SENSITIVE TO INDIVIDUAL RESIDENTS' CARE NEEDS; RAISE NURSING HOME REGULATIONS ON RESIDENTS' RIGHTS TO THE LEVEL OF A CONDITION OF PARTICIPATION; IMPROVE SURVEYOR TRAINING AND ATTEMPT TO MINIMIZE SUBJECTIVITY IN MAKING COMPLIANCE DETERMINATIONS; PROHIBIT CONFLICTS OF INTEREST FOR THOSE REGULATING NURSING HOMES; INCREASE FEDERAL FUNDING OF THE SURVEY AND CERTIFICATION PROCESS TO 100 PERCENT FOR THE NEXT 3 YEARS; AND, IMPROVE ACCESS TO FACILITIES AND RELEVANT DOCUMENTS FOR OMBUDSMEN. THESE ISSUES ARE ADDRESSED IN GREATER DETAIL IN THE POSITION PAPERS STRONGLY SUPPORTED BY AARP THAT WERE DEVELOPED BY THE CAMPAIGN FOR QUALITY CARE IN NURSING HOMES.

## CONCLUSION

IN CONCLUSION, AARP IS GRATEFUL THAT THIS COMMITTEE HAS CHOSEN TO ADDRESS MANY OF THE PROBLEMS WITH NURSING HOME QUALITY. WE COMMEND CONGRESSMEN DINGELL AND WAXMAN FOR INTRODUCING H.R. 2270, WHICH ADDRESSES MOST OF THE NURSING HOME QUALITY CONCERNS WE HAVE EXPRESSED HERE. WE URGE THAT THE IMPROVEMENTS WE HAVE RECOMMENDED ARE INCORPORATED INTO THE BILL AND OFFER OUR RESOURCES AND ASSISTANCE TO ENACT THE REFORM INTO LAW THIS YEAR.

Mr. WAXMAN. Thank you, Ms. Blood.
Ms. Rourke.

## STATEMENT OF SUSAN ROURKE

Ms. ROURKE. I am Susan Rourke. I am vice president of the National Citizens Coalition for Nursing Home Reform. I am also executive director of Citizens for Better Care, which is one of the member organizations. We are responsible in Michigan for running the long-term ombudsman program, as well as other advocacy services for older and disabled citizens in Michigan.

Citizens for Better Care supports the coalition's campaign for quality care in nursing homes, because it is clear to us that the solutions to the problems we see every day in Michigan really need the leadership from Congress and the Federal administration in order to find solutions. Proposals which I am presenting to you on behalf of the National Citizens Coalition today were developed by 20 national organizations based on the work done by the Institute of Medicine Study and the public policy positions have been endorsed by over 55 national organizations representing consumers, professionals, workers, and the nursing home industry.

I just want to highlight—I think we have talked a lot today, you have heard a great deal on the number of the issues. I want to highlight some perhaps that have not been explored in as much detail.

The first point is I think we are so pleased to see that congressional attention to nursing home quality as embodied in H.R. 2270 is being worked on. We believe that there is a National will now through this coalition to consider adopting the recommendations of the campaign. The resident assessment issues have been discussed at some length. The coalition strongly supports the resident assessment as a critical component to anything that follows in the enforcement, in the training, in the whole variety of issues.

The next step certainly is the whole issue of residents' rights. Simply because people need health care services in an institutional setting doesn't mean that they are incapable of participating in the day-to-day activities or exercising self determination.

H.R. 2270 is an important step, long overdue step, in recognizing the importance of residents' rights. However, its provisions do need a little strengthening. We would look forward to working with the staff on particular recommendations that the campaign for quality care had.

For instance, the support for the ombudsman program is essential to protect the residents' exercise of their rights. Throughout the country State and local ombudsmen programs work on a daily basis with nursing home residents, with their families, and assist them to resolve problems they face, supporting the development of resident and family councils and advocating with the residents for improvements of the nursing home system.

As we heard so very clearly from the two family members who testified this morning, nursing homes need to be required to respect residents' rights to know about ombudsman programs, and to receive those visits.

The ombudsman program should have the right of access to a facility in order to resolve the complaints that they receive. State survey agencies should work cooperatively with the ombudsman programs for their mutual goal of assuring quality care for residents.

The whole issue of aide training has been discussed a great deal. In 1978, the National Citizens Coalition for Nursing Home Reform published a paper entitled "The Plight of the Nursing Home Aide and Orderly," outlining the need for training, staffing ratios, better working conditions, and supervision. The issues that we discussed then are still before us, and we strongly support the provisions for aide training in the bill.

A national training agenda must establish minimum training standards and assure that those who provide the care meet those standards through competency testing.

We also, in addition, support the discussions around the increased numbers of nursing staff in order to provide care in the facility, to provide the nursing care that is needed for the residents.

One important service has not been discussed, and being a trained social worker, I find myself raising it in some self-interest, the issue of the social worker—provision of social work provisions, professional social work services in the homes.

Social work services are needed to assure that the social and emotional needs of residents are met during the months and years that they call a nursing facility "home," as well as linking them to the community and perhaps even eventually providing discharge planning to those who may see the need only to convalescence in the nursing home.

The physician services have only been mentioned briefly earlier, but the provisions of this bill seem to state that medical and health related services can be provided by health care providers other than physicians. We recognize the need and desirability to use nurse practitioners who are skilled in this area, and we believe that other professional services should be required if physicians' services are optional, so that there is a tradeoff.

Certainly this allowance for the missing physician, the well documented missing physician in the nursing home, should mean that professional registered nurse coverage is critical.

Additionally, the provision that nursing homes must require physicians to take care of each resident should be strengthened so that the medical community will in fact provide the services needed in institutions.

I would like to support the issues around Medicaid discrimination that Ms. Blood raised, and the number of issues around payment systems that we believe need to be tied to resident assessments.

Finally, just, if I could, Mr. Chairman, we really the Federal Government must require the States to coordinate the various enforcement programs for which it pays, including inspection of care, Medicaid fraud, ombudsman programs, as well as survey and certification.

Finally, we hope that we will see early work on the passage of this bill and the coalition and its member organizations pledge to work with you and with the committee to seek the changes we have discussed.

Mr. **Waxman**. Thank you very much. I want to commend both of you for your testimony today.

[Testimony resumes on p. 532.]

[The prepared statement of Ms. Rourke follows:]

# TESTIMONY OF THE
# NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Presented by

Susan Rourke, NCCNHR Vice-President
Executive Director, Citizens for Better Care, Michigan

to the
Subcommittee on Health and the Environment
Energy and Commerce Committee
U.S. House of Representatives

May 12, 1987

On behalf of over 300 member groups in 46 states, the National Citizens' Coalition for Nursing Home Reform commends . Congressmen John Dingell, Henry Waxman, Claude Pepper and other legislators for introducing a bill intended to promote quality of care and life for nursing home residents. NCCNHR maintains that federal attention to the key issues covered in this bill is absolutely essential and long overdue.

In 1981, Congress responded appropriately when it called for a ten-month moratorium on regressive and destructive regulatory initiatives from the Department of Health and Human Services. The subsequent legislative proposal for the government to fund a special study of nursing home regulation by the Institute of Medicine (conducted from 1984 to 1986) was also timely and significant. The report, released March, 1986, developed and reinforced reform ideas set forth over the last ten years in reports, investigations and hearings by state and federal legislative committees and private organizations.

The overall conclusion by the Committee is that the federal and state governments need to develop and strengthen the regulatory system. The IoM ideas, based on historical thinking and progress, include government attention to and development of:

(1) appropriate assessment and placement of older persons in need of long term care services, including periodic reassessment, and changes as necessary and desirable by the resident;

(2) resident assessment by a variety of health care professionals, directed by skilled nursing personnel and physicians, and including skilled therapists, social service and mental health professionals;

(3) provision by each facility of day-to-day quality services to assure that each resident receives the best possible attention to medical and health needs; maintains a maximum functioning level; and receives essential therapies for rehabilitation;

(4) promotion and maintenance of quality of life for residents:

* opportunities for life enrichment, including activities and choices, and participation in decision-making -- all important to promote quality of life;

* opportunities to participate in and to receive services and assistance from community groups, agencies and organizations;

* freedom from unnecessary restraints, discrimination and involuntary transfer, as well as maintenance of civil and

personal rights and rights as a beneficiary of government programs;

* opportunities, without reprisal, to inform and advise regulatory, ombudsman, legal services, and advocacy agencies and organizations about personal problems and needs and day-to-day facility conditions;

(5) a strong regulatory system that can assure on-going implementation of quality standards through regular monitoring and enforcement activities.

These are services, opportunities and protections which are humane and essential. None of our parents, family members, friends or neighbors should receive anything less from the important federal-state programs provided since the enactment of Medicare and Medicaid in the mid-1960's.

In fact, to settle for less, in any community, would be inhumane and wasteful. Our country does have the concern, resources and technology which are necessary to achieve these goals. If Congress does not act aggressively to enact reform legislation which includes a budget to support its provisions, we are, without doubt, making a decision and statement that we do not really care enough about our older, frail, disabled, ill citizens to provide them the quality of care and protections they both need and deserve.

In a legislative proposal, people will debate over words and phrases. All of this is necessary and understandable given the high stakes regarding these issues. But, in our opinion Congress should pay closest attention to two documents, (1) the Institute of Medicine report, Improving the Quality of Care in Nursing Homes, and (2) the set of public policy position papers contained in the Campaign for Quality Care In Nursing Homes, developed by representatives from twenty national organizations and subsequently, to this date, endorsed by over 55 national organizations.

As you know, people from a variety of disciplines with differing perspectives worked on the IoM report. After the report's release, from June 1986 to April 1987, NCCNHR convened and coordinated a series of over 30 intense discussion sessions in which the IoM recommendations were thoroughly reviewed and developed even further. This time-consuming effort included an even broader consortium of organizations representing consumers, providers of care, and health care professionals. The papers presented to your committee staff three weeks ago, were accomplished in a serious, historical effort to arrive at workable solutions to nursing home problems. The results of this major accomplishment should not be taken lightly or ignored.

This testimony presents the set of public policy position papers to your Committee and summarizes critical aspects of several key issues which, we believe, are essential to include in any federal law. These comments also present areas where we feel H.R. 2270 should be revised and strengthened.

## NURSING HOME STANDARDS OF CARE

### Single set of requirements for SNFs and ICFs

All residents of nursing homes should receive a basic level of services - including physical and mental health care and social services, as needed. This level should equal, at least, the current standards for skilled nursing facilities. Caution must be used so that any merger of both sets of requirements does not result in loss of benefits for older citizens now eligible for the intermediate level of care. If the definition of benefits for intermediate care, as now stated in regulations, is not included, there appears to be a danger that the group of people needing this level of services would be forced into a lower level of care such as board and care, particularly given the motivation of many states to cut Medicaid budgets.

### Nursing Services

There is a critical lack of qualified nursing personnel in nursing homes. NCCNHR contends that we must move aggressively towards assuring qualified Registered Nurse coverage around the clock in all nursing homes. if, however, as stated by Congressional staff, Congress will not commit itself by providing the direction and resources as needed, then it should not adopt less than the H.R. 2270 proposal for 24-hour licensed nursing services and coverage by an R.N. at least eight hours a day, seven days a week. Budget proposals should assure that nursing homes willbe reimbursed to provide these increased nursing services.

Aide Training

In addition to employing sufficient professional nurses to meet residents' needs, facilities should be required to utilize the services only of trained nursing assistants. Although good training is only one aspect of needed improvements relating to the employment and work of nursing assistants, it is extremely important and has long been identified as a basic problem in nursing homes.

A national training agenda should be initiated through federal law which requires HHS to develop criteria for training programs and competency testing. States should be required to follow this federal direction in implementing programs. Training programs at the local level, including any established in a nursing facility, should meet clear, strong federal/state requirements before the training program is approved. Regular monitoring by the state must assure that quality programs are maintained. Trainees should be salaried during the time they're training and should be protected by fair testing and appeal rights built into the training and testing system.

Physician Services

The provisions of this bill seem to state that medical and health related services can be provided by health care professionals other than physicians. While we recognize the need and desirability to utilize services of nurse practitioners and physician assistants in nursing homes, we believe that such other professional services should be required, if physician services are optional. Certainly, this allowance for the "missing physician" in nursing homes, should mean that professional registered nursing coverage is imperative.

Additionally, the provision that nursing homes must require physicians to supervise the care of each resident should be strengthened so that the medical community will, in fact, provide the services needed in institutions. Such development is in keeping with the bill's provisions which attempt to assure that the state will provide other needed services, particularly, mental health services.

## Resident Assessment

We cannot really provide or assure quality care and services for each individual unless we develop and maintain resident assessment programs in each nursing home. An individual resident assessment by qualified personnel should lead to a carefully developed plan of care which can actually be implemented by qualified staff and evaluated by well-trained surveyors through the regulatory process.

We urge the Committee to reconsider the language in its provisions relating to resident assessment and adopt the position carefully developed in our public policy position papers.

## Social Services

All nursing homes should provide or arrange for social services from qualified social service providers. Many nursing home residents need both routine and specialized social services in order to help them adjust to entry into a facility and to achieve and maintain emotional well-being in an institutional living environment. Workers, of all disciplines, need consultation and guidance on handling situations involving care of residents with severe disabilities, who suffer from despair, and must face death and dying. Qualified social workers should be valued professionals in nursing homes. This area of services is gravely neglected in all but the best nursing homes. The situation is inexcuseable.

## Mental Health

Beyond social services, we have not even begun to provide specialized mental health assessment and care needed by many residents. H.R. 2270 provisions relating to mental health appear to improve on this unforgiveable situation.

The provisions related to mental health assessment and services raise the following serious questions which must be addressed by the Committee:

(1) The actual purpose of the proposal is not clear. Is it intended (as it should be) to see that older nursing home residents receive needed mental health attention and services, or is its purpose to cut back on the nursing home population or to find alternative placement for younger persons with mental disabilities and problems?

(2) Does the population of people addressed by the provisions (as developed) now live primarily outside the institution? Are those in mental institutions expected to be "dumped" into nursing homes? If not, how will people be identified as "mentally ill" and by whom?

(3) Who will provide the mental health assessments and where? The proposal does not mention any requirements for mental health personnel in nursing homes.

(4) Where do older residents who are confused, or depressed, or "diagnosed" with Alzheimer's disease fit into these provisions? Confusion and depression can be common to nursing home residents without special services, or those given poor care and treatment, but such persons are not necessarily mentally ill.

(5) If residents are dismissed to other settings, how will we assure that they get the services they need there any more than we can now within a nursing home?

(6) Who makes the final determination that a resident does not need nursing services or active treatment in a facility? What protection, including appeals, do residents have regarding these specific provisions?

Residents' Rights

H.R. 2270's attention to residents' rights is of great significance. We believe that federal law should lay the groundwork to assure that citizens who live in nursing homes do not lose their basic rights as citizens or beneficiaries of Medicare or Medicaid as well as their personal rights. We applaud recognition in this proposal of the rights of residents to be free from unwarranted, misused psychotropic drugs.

In addition to nursing facilities providing written notice to residents of their rights, we urge you to include provisions which assure that nursing home staff advise residents of their rights and encourage and assist them in the exercise of these rights. Nursing homes should also be required to post information about the officially designated state/local ombudsman and the state survey agency, and to inform residents about their right to make complaints without fear of reprisal.

Of great importance is inclusion of the right of residents, along with their family members, to maintain and participate in resident councils and family councils, and other forums for resident and family participation, the meetings of which shall be afforded privacy and facility space.

To strengthen H.R. 2270's provisions regarding bed-hold policies, the nursing home should provide residents with notice of residents' right to request any available Medicaid bed hold prior to hospital or therapeutic leave, to the extent provided by state law, and should provide residents with notice at least three business days prior to the lapse of the bed hold days.

To strengthen H.R. 2270's provisions regarding transfer, decisions about transfer and documentation should be required to be based on a multi-disciplinary assessment, as verified by a physician. Registered nurses, social workers and other health care professionals are often in a primary position to help make these decisions. Legislation should clearly state that the resident's own welfare is paramount and that a transfer which would endanger a resident's welfare is not acceptable. Legislation should instruct HHS to develop regulations providing protections for residents' rights in transfers within the facility as well as transfers outside the facility.

Medicaid Discrimination -- Equal Access to Quality Care

H.R. 2270's provisions to explicitly prohibit practices which deny Medicaid beneficiaries access to their entitlements are commendable and offer long overdue enunciation of federal positions.

However, H.R. 2270 does not go far enough in providing access to quality care for Medicaid beneficiaries. It should be strengthened to include provisions that the nursing home be required to care and provide services to all residents in such a manner as will meet their quality of care and quality of life needs in compliance with federal and state requirements. Provisions should also prohibit nursing homes from making room assignments based on source of payment, except to the extent that private rooms are not included in the state Medicaid plan.

Most importantly, there are serious problems to be addressed about access for Medicaid beneficiaries to nursing homes. Older citizens without sufficient personal resources to pay privately for their care are still clearly in need of care and services offered by facilities with Medicaid certification. Too often, they are denied facility admission because the nursing home prefers a private-pay client who can be charged more for the bed.

The system, as it operates, constitutes a broken promise to those who have contributed throughout their lives to the Social Security system, only to find that its benefits are not available to them in their time of greatest need. NCCNHR urges the Committee to direct its staff to work with consumers and providers of care to move towards a solution to this critical problem.

## SURVEY, CERTIFICATION, AND ENFORCEMENT ISSUES

Major improvements in state and federal government oversight of nursing home compliance are necessary to assure that nursing home residents receive quality care. Provisions of H.R. 2270 will make an important contribution to this monitoring and enforcement effort; although we are presenting reasons for revisions to make it even stronger.

Effective enforcement must rely on the strength of the entire regulatory system -- the quality of the standards to be enforced; the quality of the personnel implementing the enforcement program; the resources available to support the effort; the effectiveness of the inspection process; the coordination with other agencies; and the training of surveyors and supervision for the program. H.R. 2270 addresses many of these issues effectively.

Inspections of nursing home conditions should focus on outcomes and results of the care and services provided by each facility. However, regulations must provide the basic direction nursing homes need to assure that good outcomes are possible. Nursing homes need sufficient numbers of trained staff to provide good care as well as qualified professionals to supervise nurse aides and direct programs of care delivery.

As proposed in H.R. 2270, more effective standards of care directing the delivery of services will make a significant difference because such standards will provide a better measuring rod for surveyors to use to evaluate nursing home conditions. For example, the resident assessment system will provide valuable information to surveyors about residents' conditions and a facility's responses and interventions over time. Standardization of nurse aide training program and testing requirements will assist surveyors in reviewing the quality of the trainings as well as the quality of care aides provide.

To strengthen government enforcement efforts even further, we urge you to address the following concerns and principles:

(1) Improved training and resources for survey staff

Good surveyors are key to effective enforcement. H.R. 2270 should include additional provisions to require initial and on-going training and competency testing for surveyors, and resources for survey staff with special knowledge of health care issues or expertise in enforcement practices.

Surveyors need better training, initially and throughout their employment. Training should cover all the services included in the Conditions of Participation, because surveyors are often expected to evaluate services outside the professional disciplines for which they have been trained. Training is also necessary for skills development to assist surveyors in communicating with residents, and in investigative techniques and other areas necessary to gather information and develop defensible deficiency reports.

Current resources make it prohibitive for states to maintain a diverse staff of surveyors. Professionals representing many areas of expertise -- such as social work, activities, therapy, and mental health -- are rarely available to state survey teams. Yet these care areas are extremely important to surveyors evaluating the quality of life available to nursing home residents. States are limited in their ability to monitor quality of care issues as well. Rarely are states able to send out a team consisting at least of a nurse, a dietitian and a pharmacist. Few states have the back-up staff to assist regular survey teams to evaluate health care or develop a strong case for enforcement.

(2) Effective survey process

Nursing home inspections provide information about conditions at a facility on a given day. Despite attempts by state agencies to make surveys unannounced, facilities are rarely surprised when surveyors arrive. Varying the survey cycle over a nine to fifteen month period may increase the element of surprise. Still, surveys offer the state agency a snapshot in time. Therefore the surveys must contain procedures for review which provide the ability to understand how the nursing home has functioned in providing care and services to residents over time.

Additionally, survey agencies should coordinate their activities with the long term care ombudsman program which has a daily presence in nursing homes and the ability to monitor conditions before the survey team arrives and long after it leaves. Survey and certification programs should be required to maintain a working agreement with ombudsman programs for coordination of problem investigation and resolution, information sharing, and training.

H.R. 2270 contains two major changes in the survey and certification process which raise concerns for advocates about the ability of the survey system to protect each nursing home resident and to detect problems before they become so serious that residents are greatly injured:

(a) the merger of the Inspection of Care program with the Survey and Certification program, and

(b) the development of a standard and an extended survey.

Both provisions are based on recommendations of the Institute of Medicine Study Committee and have been the subject of public discussion for many years. Unfortunately, while each proposal has some merit and addresses legitimate concerns, both have most often been considered in the context of budget savings. If they are implemented in this context, consumer concerns about potential adverse affects may well be realized.

The Inspection of Care has a unique focus on the actual care each and every Medicaid nursing home resident receives. The Social Security Act requires state Medicaid agencies to review annually the appropriateness and adequacy of care for each Medicaid nursing home resident. This review is generally conducted by an interdisciplinary team of health care professionals who evaluate the care each resident requires and receives, based on the team's observations of the resident's condition and its review of the medical records.

The survey and certification process has a different function -- to focus on the overall care provided by the facility and the facility's compliance with certification standards.

The Institute of Medicine Study Committee rightly pointed out that there is great value in changing survey procedures so that evaluation of a facility's compliance is based on the care residents actually receive. The new HCFA long term care survey process, implemented last summer, is a step in the right direction. Yet it is not a substitute for the individual oversight provided by the Inspection of Care process, when it is correctly applied.

HCFA's new survey process has yet to develop an adequate methodology for choosing a sample of residents which is both representative of all aspects of the resident population and allows for in-depth review of care problems once they are identified in the sample of residents. Current survey teams do not have the interdisciplinary expertise or the time to review each resident's care individually. Surveyor training for the new survey system has been inadequate in the areas of communication skills as well as deficiency detection, and the trainings offered by HCFA have reached only a small portion of surveyors nationwide.

The Tenth Circuit Court, through its jurisdiction over the Smith v. Bowen case, has ordered HCFA to publish new regulations to improve its survey process and has determined that its actions to date do not constitute a sufficient remedy to the federal government's failure to assure that nursing home residents receive quality care.

Using a review of care provided to a sample of residents can substantially improve the survey process, yet it does not offer specific protections to assure that each resident receives appropriate and adequate services.

Strengthening the Inspection of Care process, and coordinating activities of the Inspection of Care program with those of the survey and certification program, rather than merging the two programs, provides the greatest possibility for improvement (especially if this is done with the hope of saving money, and thus losing professional staff and the focus on 100% of the Medicaid nursing home residents). The survey system would then have the benefit of the information currently gathered during inspections of care and rarely used or reviewed. Thus the findings of Inspection of Care teams would have greater clout and could supplement the findings of the survey teams.

The merit of the concept of standard and extended surveys lies [illegible] quality of the standard survey. It should not be viewed as a partial survey of only selected requirements. Nor should it be applied only to good facilities. The survey should contain key indicators of quality care with reliable triggers to additional review of larger numbers of residents and more in-depth evaluation of service systems within the nursing home. The current survey system already contains a standard and an extended review, in that surveyors must extend their examination of facility conditions if their initial review uncovers problems.

When standard and extended surveys have been proposed in the past, it has often been in the context of budget constraints - as a means for focusing resources on the worst facilities; or as a way to "reward" facilities with good track records by relieving them of the "burden" of government oversight.

Each nursing home resident deserves the protection and oversight provided by the state. In many nursing homes which provide generally good care, an individual resident may experience care-related or rights-related problems. Conditions in "good" facilities can change overnight with a significant change in personnel or a change in ownership or management.

In other nursing homes deficiencies in care and services are not readily apparent and only become apparent through a thorough review of the care provided. Unfortunately, by the time care problems become obvious, their sources have become deeply rooted and the resulting "outcomes" present serious problems for the residents who have received poor care over a long period of time.

There are also facilities in which the pattern of poor care practices is evident within the first few hours of a survey. Quite often, their poor care practices have been present for a long time before they became evident. Earlier recognition and correction could have saved residents from a great deal of pain and suffering and the state from exhausting enforcement activities.

A standard survey should only be used if it can enhance the survey team's ability to identify and pursue care problems within each facility it reviews in all areas which federal certification standards address. The extended survey should be a natural outgrowth of this survey utilized in full or in part to explore any potential problems.

(3) Monitoring the effectiveness of state action

The federal government should review state performance based on:

- a comparison of findings from look behind surveys with state survey team findings;
- the prevalence of repeat deficiencies and uncorrected deficiencies;
- the general improvement in conditions in nursing homes in the state;
- the appropriateness and effectiveness of state use of enforcement actions.

HCFA should establish sanctions against states commensurate with the proportion of residents placed at risk by the failure of the state to provide adequate protections for Medicaid beneficiaries. However, monetary sanctions may not be the best solution. In an era of fiscal restraint, such action could seriously damage the capacity of the state to correct its problems and adequately protect residents.

Coordination between state and federal government is essential for effective enforcement. We applaud the H.R. 2270 provisions to coordinate federal financial participation with state enforcement activities and to clarify the relationship between federal and state findings and enforcement decisions.

### (4) Enforcement actions

Enforcement actions should be developed to respond to the severity and frequency of deficiencies, including more severe actions against chronic or repeat violators. The range of actions should include actions in place of decertification as well as actions to correct deficiencies and protect the health, safety, welfare and rights of residents.

While we realize a great deal of this detail cannot be incorporated in legislative text, we urge the Congress to make its intentions clear to guide the Department of Health and Human Services in the implementation of these provisions. HCFA often proceeds without soliciting participation from all concerned parties. Historically this Committee has directed HCFA to proceed in an open process with maximum participation from all who have experiences and expertise that can constructively assist the Department in developing sound regulations.

This legislation is too complex, too comprehensive, too important, to be relegated to the closed offices of the federal bureaucracy for implementation. Surely the collective wisdom and experience and genuine interest and concern of the representatives of state regulatory agencies, consumers and their advocates, nursing home workers, nursing home providers and health care professionals can contribute greatly to the development of a good regulatory system.

Additionally, we urge the Committee to incorporate the establishment of a Commission on Nursing Home Care (as proposed in S. 1108) into H.R. 2270. The Commission should:

* oversee HCFA and state implementation of the provisions of this bill, and

* pursue issues of continuing concern not included or fully addressed in this year's legislation, including: equal access to quality care for medicaid beneficiaries; improved reimbursement procedures to assure that adequate funds are available and appropriately utilized to provide quality care for residents; adequate staffing levels and better working conditions for nursing home employees; the mental health needs of nursing home residents; and other important issues needing continued discussion and action.

Membership on such a Commission should be representative of all perspectives. The Commission should report regularly to Congress. The Department of Health and Human Services should be required to respond to the Commission's recommendations with timely proposals for action.

In closing, NCCNHR emphasizes: We have an unprecedented opportunity to reform our laws to improve nursing home services and the regulatory system. In a society with such riches and resources, we should not be forced to settle for less than high quality services and benefits for our older and younger citizens who need to live in institutions. Although we realize that Congress must deal with the budget deficit, we also believe that we will be irresponsible if we do not act now while we have full support for long overdue reforms.

Nor should we play political soccer with a bill that is so critical to one of the most vulnerable groups in our society. We urge the Committee to direct its staff to work with all concerned parties to incorporate our recommended changes into H.R. 2270. They are based on the intensive work of several national organizations over the last year. The organizations which have worked so diligently and responsibly to develop proposals on issues addressed in H.R. 2270 represent every sector of society and a strong public will to achieve quality care.

We also urge you to consider significant proposals set forth by Senator George Mitchell and others from the Senate Finance Committee's Subcommittee on Health, who are committed to enacting quality care legislation.

If the committee needs more motivation to act than that provided by public witnesses at this hearing, NCCNHR and other organizations can supply filing cabinets full of well-documented regulatory actions, legal cases, and newspaper investigations, that testify to the poor conditions in this country's nursing homes. We hope, however, that this is not necessary in order to influence action on recommendations so well studied and well stated by concerned parties.

Our organization urges you and offers support for you to amend H.R.2270 as recommended and to assure its adoption this legislative session.

Mr. WAXMAN. Let me ask each of you, do you believe that the enforcement provisions found in H.R. 2270 are adequate, and what changes, if any, would you recommend? Ms. Blood.

Ms. BLOOD. We support the provisions in the bill, noting that there seems to be one missing element, and that is that States must be forced to use their existing enforcement mechanisms.

As an example, in the State of Maine, it took 2 years to get a receivership law in place, and since that time we have had three incidents where they just screamed and cried out for receivership, and the State didn't use it, and it ended up with a whole nursing home full of residents. They had no place to put them, opened up a wing in the mental health institute, and moved them all over. So that again I just underscore the States must be somehow forced to use those mechanisms that they do have available to them.

Ms. ROURKE. I'd simply agree with Ms. Blood. In Michigan again, we've had, for very long, some provisions which look very good which have not been used. We are talking here, I believe, about the proper mix of the Federal and State relationship, and the strengthening the look behind authority and use of the Federal Government to pull a State in to assure that those enforcement mechanisms is used is certainly one way to do it, that we would be concerned. That partnership must exist. It isn't only a State issue or a Federal issue, I would believe, some sort of partnership.

Mr. WAXMAN. Now we have had months of discussion about the issue of discriminatory admissions practices with regard to residents' source of payment. I believe that while the approach taken in our bill is not perfect, it would certainly go a long way in protecting Medicaid beneficiaries against discriminatory admissions practices. In fact, the bill tries to implement the consensus position forged by the National Citizens Coalition for Nursing Home Reform.

How do you think we can improve the bill without placing the homes in an untenable financial position? I know, Ms. Blood, you had an idea, looking at some proportion for each home before——

Ms. BLOOD. Right. That was the fair share, where if a facility had their fair share of Medicaid beneficiaries, that this would be based on the average census in the homes of that State, and that we were relating it to the experience in California where it showed that it did not have the financial impact, and apparently did not have an adverse quality impact either.

Mr. WAXMAN. Ms. Rourke, what do you think of that idea, or what do you think of the provision that is in the bill?

Ms. ROURKE. I can only begin by saying it is certainly a problem. We see it every day in Michigan. The idea that Ms. Blood has proposed is one of a number. There are a number of States that have implemented a variety of different approaches.

I want to say two things. I think whatever is in the legislation needs to be very clear. One of the great difficulties we have had in seeking resolution to any problems at the State level is a lack of clarity and understanding in what the Federal initiative is, what enforcement mechanisms we can use.

Second, I think in terms of the fair share idea, or a variety of other ideas, I would hope that one of the opportunities that the committee would offer is for the people in the coalition and other interested parties to sit down and look at these in detail, and perhaps craft some language that could be put in that would meet the parties interest. But clarity is important. We have fought very long in Michigan through a series of HCFA steps and other steps, and were not able to find resolution because nobody seemed to know who was responsible.

Mr. **Waxman**. Well, I appreciate that suggestion. We will look forward to working with both of you on this legislation. Thank you very much.

That concludes the business before the subcommittee. We stand adjourned.

[Whereupon, at 3:35 p.m., the hearing was adjourned.]

[The following statements and letters were submitted for the record.]

## STATEMENT OF BEVERLY ENTERPRISES

Mr. Chairman and members of the Subcommittee, Beverly Enterprises is pleased to have this opportunity to comment on the proposed "Medicaid Nursing Home Quality Care Amendments Act of 1987." As a provider of long term health care services, Beverly Enterprises, with 166,000 employees, delivers care every day to more than 100,000 patients in 1120 nursing facilities; home health agencies; pharmacies; retirement living communities; and durable medical equipment agencies in 41 states and the District of Columbia.

In commenting on the legislative proposals, we would like to refer to the Institute of Medicine's (IOM) report, Improving the Quality of Care in Nursing Homes...(page 24)

> "An effective regulatory system cannot be a static structure; it has to be conceived as being dynamic and evolutionary."

In keeping with the aforementioned principle, everyone would agree that the primary objective of policy makers' should be the quality of care provided to the patients. Theses policies need to be modified periodically to keep pace as new knowledge becomes available on caring for nursing home patients. The resulting governing structure should reflect an understanding of a facility's performance, the characteristics of its residents, and allow for adjustments to meet the need for a variation in the facility's services.

We would emphasize that the services that nursing homes provide are dependent on having trained personnel, at all levels, being responsible for the delivery of patient care on a daily basis. That care must be professional, personal, and it must be tailored to meet the specific needs of the patients.

The heterogeneous population to which nursing facilities provide care, requires that the the facilities assess the individual patients' conditions. These needs then become the determining factor in designing the appropriate "plan of care" as proposed in Section 1921 (b)(2) of this legislation. From that plan, facilities can design staffing criteria sensitive to facility case mix - that is, the variations in the services required and outcome expectations for residents with differing needs in the facility.

We endorse the legislation's intent to require assessment of each patient admitted to a facility. A facility's nursing staff structure becomes, under this approach, one product of the compilation of all of the patient plans of care in the facility.

Because of the changing nature of those plans, we oppose mandating specific inflexible staff ratios either by legislation or regulation. Nursing home services range from medical and therapeutic for the treatment and management of chronic illness, to personal assistance with basic living activities. Professionals, both in the provision of nursing care and the management of that process who are trained to assess patient needs, should be charged with the responsibility for developing the plan of care for each patient. We would also caution against the blind acceptance of the evaluation of a facility's or a company's performance based on arbitrary staffing formulas whether by employee hours or staff to patient ratios.

The Chairman and Committee are to be commended for their diligence in recognizing that the expectations of care and services provided to nursing home residents must correspond to the characteristics of the residents.

In this context, Beverly would like to comment on Section 1921 (b)(3) of this legislative proposal as follows:

> Resident Assessments are integral to quality care and provide the nursing home with a valuable guide for establishing appropriate care plans. Such assessments allow nursing home managers to maximize their coordination and responsiveness to their patients' health care needs. We endorse this Section 1921 (b)(3) of H.R. 2270.

With regard to the proposed Section 1921 (b)(6), we would comment that:

> Physician Supervising - We support the Committee's efforts to ensure that all nursing home residents' care be supervised by a qualified physician. Nursing facilities should be required to assure that emergency physician services are available on a 24-hour basis. We endorse Section 1921 (b)(6) of H.R. 2270.

It is often noted that trained nurse aides deliver the majority of the "patient care" in nursing homes. It is also true that the care level improves when those aides are well trained and then supervised by trained professional managers. Historically, we have developed and provided to the staff in our facilities training resources through our operating divisions. That has confirmed to us the benefits of providing inservice training programs for all employees. Beverly Enterprises is addressing training from two perspectives, (1) by developing aide training programs in our facilities and, (2) by establishing a Corporate Training Center.

The Center will begin offering courses in July of 1987, and it will be dedicated to the continued professional education of supervisory personnel. Programs will be taught by qualified facility personnel and all currently employed and newly hired Administrators, Directors of Nursing, Dietary

Supervisors, Social Workers, Activity Directors, Directors of Housekeeping and Business Office Managers will attend. The curricula are designed for each of the disciplines and will focus on:

- Quality Assurance
- Management Development
- Human Resources
- Financial Management Training
- Long Term Care Philosophy

As to the proposed legislation Section 1921 (b)(5) of H.R. 2270, we would comment that:

> Nurse Aide Training - Competent staff, at all levels, is necessary to provide quality health care services. The states should be encouraged to assure that training programs are realistically related to the actual duties performed by the affected individuals. We endorse this Section 1921 (b)(5) of H.R. 2270.

We have carefully reviewed the proposed legislation regarding the assurance of quality services and found it to be somewhat similar to the approach we have been developing for our internal operating purposes. In 1976, Beverly Enterprises began developing a Quality Assurance Program focused on all aspects of patient care. That initiative has evolved into a Quality Assurance Program today that contains the following three components:

Continuous Quality Assurance Review - A review of the facility by trained personnel at least four times a year. The Quality Assurance review utilizes the Quality Assurance checklist based on criteria adopted from federal and state conditions of participation as well as other nationally recognized professional standards of performance. Based on the results of facility surveys, a "plan of action" is developed to improve care, correct problems and mechanism are formulated to prevent their recurrence.

Opportunity for Patients, Families, and Staff Comment - A toll-free, 24-hour, "800" telephone number provides residents, families, employees and any other interested persons an opportunity to offer comments and suggestions. Notification of the "800" number is posed conspicuously in large block-lettered posters in each facility.

Review of Federal Survey Results - State licensure surveys of each facility, based on Federal certification standards, are reviewed to identify areas for corrective action.

The Chairman, in his introductory remarks on May 12, acknowledged that "Quality care is not budget neutral." Indeed, in an era when balancing the federal budget increases the demand on the limited funds for domestic programs, the Chairman's point needs to be emphasized.

In many states, the Medicaid program is currently the source by which states are controlling their budgets. Such efforts have included, for example, requiring the elderly to spend-down to as low as 50 percent of the poverty level in order to be eligible for Medicaid benefits. Congressional efforts to improve nursing home care through new legislation must require that State Medicaid payments for patient care be reflective of their share of the "full and actual costs" of meeting those standards. We have several concerns in this area.

It is publicly acknowledged that not all State Medicaid payments are sufficient to meet the "full and actual costs" of patient care services in a nursing home today for Medicaid patients. That difference is currently having to be funded by other means, principally by private patients.

Several states have predominantly relied on the "Intermediate Care Facility" level of service for their Medicaid patients in nursing homes. This legislation's initiative to mandate one level of service, approximating that of the current "Skilled Nursing Facility" will have a significant disproportionate cost impact on those states and their providers. The current Medicaid Federal/State funding formula is not sufficient to meet the costs of the necessary initiatives by the states and providers without supplemental funding. A precedent case exists when this Subcommittee provided for 100 percent Federal funding of the states' costs for previously reforming the survey process for the certification of nursing homes.

For those reasons, we recommend two proposals for the Subcommittee's consideration as to the funding of this legislation's reforms. First, that there be a specific amendment providing for 100 percent pass through to the states and their providers of their proportionate cost of complying with this legislation. This "pass through of costs" should be unrestricted by any otherwise applicable "formulas", "caps", or "ceilings".

We also strongly support the proposal that nursing homes who care for a disproportionate number of public assistance patients be granted a "disproportionate share" adjustment of a fixed percentage of their total Medicaid reimbursement.

In closing, we would like to thank the Chairman and the Committee for this opportunity to comment on the "Medicaid Nursing Home Quality Assurance Amendments Act of 1987".

**Statement by**
**Robert Elliott, President**
**National Association**
**of**
**Boards of Examiners**
**for**
**Nursing Home Administrators**

The National Association of Boards of Examiners for Nursing Home Administrators (NAB) appreciates the opportunity to comment on the provisions of HR 2270 dealing with standards and licensing of nursing home administrators.

I am Robert Elliott, the elected President of the Association. I have been a nursing home administrator for 12 years. My present position is Executive Director of Presbyterian Homes and Services of Kentucky. I have just completed a three year term as Chairman of the Kentucky Board of Licensure for Nursing Home Administrators and was a member of the Board for three years before that.

Members of the Association are the State Boards charged with the responsibility of licensing nursing home administrators. Founded in 1970, the Association pursues the following objects:

- to consider questions of common interest to the nursing home administrators' examination and licensing boards and authorities;
- to study and recommend professional and educational standards for nursing home administrators;
- to cooperate in obtaining uniformity of laws, rules and regulations, and procedures concerning state examining and licensing agencies;
- to consider, establish, and maintain a uniform code of ethics and standards of professional conduct and practice for Boards of Examiners of nursing home administrators;
- to work toward reciprocal endorsement and/or recognition of nursing home administrator licenses by the licensing boards.

I commend Chairmen Dingell and Waxman, and the Subcommittee, for seeking to bring about positive change in the current Medicaid nursing home regulatory system. However, this Association opposes the development of standards by the Secretary "to be applied in assuring the qualifications of administrators of nursing facilities." It therefore also opposes the repeal of Sections 1902(a) (29) and Section 1908 of the Social Security act which mandate a State program for the licensing of administrators of nursing homes.

The reason for our view is that the State program for licensing administrators of nursing homes set up by Section 1908 of the Social Security Act is working! There is no reason to interfere or tamper with administrator licensure. Rather, the States should be allowed to build upon the considerable progress which has been made.

To place this progress in perspective, one need only recall the situation which existed prior to the Social Security amendments which mandated licensure of administrators.

One author wrote in 1974 "In the not too distant past, the nursing home administrator was looked upon as hardly more than a titular position. In some homes the position was non-existent and in many this was handled by persons unaware of their responsibilities or their functions and with little guidance."[1]

As a result of licensure and the work of the State boards the situation today is far different, as will be demonstrated subsequently.

When Senator Edward Kennedy introduced his bill in 1966 which required States to establish programs to license nursing home administrators, he was motivated by a variety of studies done on nursing home administrators. One study conducted by the Massachusetts Department of Public Health showed that only 18% of those administrators had completed college, 20% had not completed high school and 10% had no formal education at all. Since only 41% of those surveyed responded, the Senator concluded that for the 59% who did not respond the results might have been even more disappointing.[2]

Compare those results with the type of candidates that are sitting for the licensure examination now.

In a study prepared for our Association by Professional Examination Service (which is under contract to provide expert assistance to the Association in the development and administration of our national examination), 25% of the candidates sitting for the examination in 1972 were high school graduates and 12.5% were college graduates. By contrast, in 1983 9.6% had only a high school education and 26.9% had done graduate work. The proportion of candidates with a college degree in 1976 increased by about 42% from 1972 levels, whereas the proportion with a college degree increased from 1976 to 1983 by more than double.[3]

Another measure of progress is to look at the way in which the States have raised the educational requirements for licensure.

A study of State statutes for licensing nursing home administrators by the Medical Services Administration of the U.S. Department of Health Education and Welfare (HEW) showed the following data as of July 1971:[4]

- In 1970 there were only 13 states which required a high school education or its equivalent. In one other state the requirement would become effective in 1971 and in another state in 1972;
- Seven states had adopted a requirement for two years of college: one to be effective in 1972, five in 1975 and one in 1977;
- Five states had adopted a requirement for a BA degree: one to be effective in 1972, four others in 1980.

The Association's own report[5] in 1986 shows clearly the progress which the States have made in raising the educational requirements for licensure:

- All States require at least a high school education or equivalent
- All except eight States require education and/or training beyond the high school level.
- Fourteen states require an AA degree or two years college as the minimum requirement.
- Twenty states require a BA/BS degree.

These figures show that substantial progress has been made by the States in raising educational standards. Futhermore, the process continues. Florida, for instance, will require an AA degree in health care administration for licensure in 1988 and a BA degree in health care administration in 1992.

Admittedly, nursing home administrators have not reached the stage of older health professions where a degree is an indispensable requirement for licensure and employment. This profession is still an emerging one.

While there is diversity in educational requirements, State licensing boards do have a national examination which helps them differentiate in a reliable way those applicants who are able to demonstrate a minimum level of competence and those who cannot. Forty nine states and the District of Columbia now use the national licensure examination developed by this Association in cooperation with Professional Examination Service.

The national examination is based on the overall job functions and responsibilities as well as the underlying knowledge, skills and abilities that are essential to ensure competence at the entry-level for nursing home administrators. The examination is continually reviewed and updated and at specified intervals a complete study is done to make sure that the test specifications keep pace with the changes in the field of nursing home administrators.

Such a complete reassessment of the test specifications was done in 1986. This Association, in a joint effort with the American College of Health Care Administrators, contracted with the Professional Examination Service of New York to conduct a role delineation study of the nursing home administrator. The project consisted of two stages.

In the first stage a representative group of experts identified the major performance domains for the nursing home administrator. They then developed the component tasks underlying each performance domain. Then these experts identified the knowledge and skills associated with the successful performance of each task. In the next step the group rated the performance domains and tasks with respect to their importance and criticality for defining acceptable performance on the job. With this information in hand, the group then determined the exact test content outline for the examination and the proportion of test items to be included in each section of the examination.

The second stage of the project consisted of a validation study to determine if the test specifications, as developed by the experts, actually describe the work of a nursing home administrator. A 16 page survey was mailed to a statistically valid sample involving 1,000 nursing home administrators and educators who were asked to rate the importance, criticality and frequency of each job/performance domain and to include any domains that may have been overlooked.

The final product of the multi-phase role delineation research was a revised set of test specifications for the NAB licensing examination for nursing home administrators. Professional Examination Service in its report states "These assessment procedures maintain the content validity and job-relatedness of the licensing examination for the entry level nursing home administrator."[6]

The test specifications cover six major areas or domains: patient care; personnel management; financial management; marketing and public relations; physical resource management; and laws, regulatory codes and governing boards. Under each domain, the specifications identify the major tasks that an administrator has to perform and identifies the body of knowledge needed in each instance to perform those tasks. In all there are 28 major task statements and 197 areas of knowledge identified.

A copy of the test specifications is attached as Exhibit A.

The items for our national examination are written by practicing administrators and educators. Each item is reviewed and revised by psychometricians and editorial experts and is then reviewed by several content experts in the field of nursing home administration. Finally, our examination committee, a group of experts in long term care, selects for inclusion in the test those items that tap the knowledge and skills essential for minimally competent entry-level practice.

Through this process, State licensing boards have assurance that the national examination

1) is related to the job of the nursing home administrator; that it
2) measures the knowledge, skills and/or other abilities that are essential to safe practice; and that
3) it has been documented that the weights given to various topics bear a reasonable relationship to the critical or important parts of the entry-level administrator.

The national examination has been revised in accord with these specifications effective January 1987.

Another measure of progress made by the State licensing boards is the number of states which require applicants to complete an administrator-in-training program. In 1971 at the time of the study done by HEW referred to earlier only five states had such programs in operation. Today, there are 34 States with such a requirement. These programs are intended to teach the administrator-in-training how the field of health care administration is best practiced and to become qualified professional administrators.

Attached as Exhibit B is a brief description of a typical State Administrator-in-Training Program, as published by the Virginia Board of Examiners for Nursing Home Administrators. Further information may be found in this Association's publication Guidelines For Conducting An Administrator-in-Training Program.[7]

The States have also provided statutory incentive for administrators to maintain and improve their level of competency by mandating continuing education requirements for license renewal. All but eight have such a requirement, ranging from 15 clock hours for one year renewals to 72 hours for two year renewals.

To assist the States in monitoring continuing education programs, this Association has established its National Continuing Education Review Service. Under this program we have established criteria regarding subject matter, faculty, learning objectives, teaching methods, sponsors and feedback from attendees. A panel of reviewers experienced in long term care evaluates programs submitted and are approved if they meet the criteria. Twenty nine states currently recognize for continuing education credit courses approved by the Association's Review Service.

The need to meet continuing education requirements, as well as the need to prepare for the national licensing examination, have encouraged the establishment of scores of college degree programs with a major in long term care administration, as well as textbooks, study guides, seminars, workshops and home study courses aimed at the training and development of the nursing home administrator.

There has been a concerted step-by-step effort by the States to improve the administrator licensing process. The program to upgrade the qualifications of the administrator is working. To interfere with that process would be a step in the wrong direction. To impose national standards would impose an undue economic burden on some states, especially on those states where the Federal share of Medicaid is the highest. We believe the Committee should leave the regulation of nursing home administrators where it properly belongs, namely, at the State level.

There is an assumption in the Bill that the repeal of the Federal licensing requirement will have no effect upon the continued existence of licensing boards. Section 4 (a) (5) (C) provides "If a State finds that a nursing facility has provided poor quality of care, the State shall notify . . . the State board responsible for the licensing of the nursing facility administrator at the facility". There is no guarantee that there will be a licensing board in each state if the Federal requirement for a State licensure program is repealed as called for the Bill.

True, the repeal of the Federal requirement would have no immediate impact upon the existence of State boards, since they exist by State statute. But what will be the effect upon State legislators looking for cost saving measures if there is no Federal requirement? Will the boards be sunsetted? It is a risk which should, and can, be avoided.

In summary, we urge the Committee not to tamper with administrator licensure. Let the States continue to build upon the considerable progress which they have made.

The Association will be pleased to assist the Committee on these matters in any way it can.

## REFERENCES

1 Wallace, Sidney D., Nursing Home Administration: The Administrator's Role, Futura Publishing Co., Inc., Mt. Kisco, N.Y., 1974, p. 112.

2 Dickler, R.M., Nursing Home Administrator Licensure: The Law Outputs and Outcomes, Association of Univ Programs in Health Administration, Washington D.C., 1974, p. 6.

3 Medicaid, State Statutes for Licensing Nursing Home Administrators: Selected Provisions; Technical Assistance Series-Number 6; Medical Services Administration, United States Department of Health Education and Welfare, 1971.

4 Schoon, Craig G. and Hayez, S. Karim, "Characteristics of Candidates for Licensure and Performance on the Nursing Home Administration Examination 1983 Update"; Professional Examination Service, New York, N.Y., 1984.

5 State Roster of Licensure Boards, National Association of Boards of Examiners for Nursing Home Administrators, Washington D.C., 1986.

6 Hayez, S. Karim and Wilets, Ilene, A Report on the Role Delineation Study for the National Association of Boards of Examiners for the Nursing Home Administrators Licensing Examination, The Professional Examination Service, New York, N.Y., 1986.

7 Guidelines for Conducting an Administrator-in-Training Program, National Association of Boards of Examiners for Nursing Home Administrators, Inc., Washington D.C., 1981.

EXHIBIT A

## TEST SPECIFICATIONS

The NAB/NHA Licensing Examination

### DOMAINS OF PRACTICE

| | |
|---|---|
| (26%) | PATIENT CARE |
| 6.0 | Nursing Services |
| 3.3 | Social Services |
| 4.1 | Food Services |
| 3.3 | Physician Services |
| 2.0 | Social and Therapeutic Recreational Activities |
| 2.0 | Medical Records |
| 2.0 | Pharmaceutical Services |
| 3.3 | Rehabilitation Services |
| (22%) | PERSONNEL MANAGEMENT |
| 4.1 | Maintaining positive atmosphere |
| 2.0 | Evaluation procedures |
| 2.0 | Recruitment of staff |
| 2.0 | Interviewing candidates |
| 2.0 | Selecting future employees |
| 3.3 | Providing staff development and training activities |
| 3.3 | Personnel policies |
| 3.3 | Health and safety |
| (18%) | FINANCIAL MANAGEMENT |
| 6.0 | Budgeting |
| 4.0 | Financial planning |
| 4.0 | Asset management |
| 4.0 | Accounting |
| ( 6%) | MARKETING AND PUBLIC RELATIONS |
| 4.0 | Public relations activities |
| 2.0 | Marketing program |
| (10%) | PHYSICAL RESOURCE MANAGEMENT |
| 2.0 | Building and grounds maintenance |
| 2.0 | Environmental services |
| 4.0 | Safety procedures and programs |
| 2.0 | Fire and disaster plans |
| (18%) | LAWS, REGULATORY CODES/GOVERNING BOARDS |
| 12.0 | Rules and regulations |
| 6.0 | Governing boards |

# TEST SPECIFICATIONS

# NATIONAL ASSOCIATION OF BOARDS OF EXAMINERS OF NURSING HOME ADMINISTRATORS

## 10.00 PATIENT CARE

10.10 Task: Plan, implement, and evaluate nursing services provided to patients to maintain their maximum health potential.

Knowledge of:

10.10.01 Restorative nursing
10.10.02 Rehabilitation
10.10.03 Medical terminology
10.10.04 The definition, concept, and procedures of nursing
10.10.05 Infection control procedures related to patient care
10.10.06 Drug administration

10.20 Task: Plan, implement, and evaluate a social services program for residents/patients that will meet their psychological and social needs and rights.

Knowledge of:

10.20.01 Patient rights
10.20.02 Social, emotional, and financial needs of patients and their families
10.20.03 Interpersonal relationships
10.20.04 Social worker functions
10.20.05 Spiritual consultations
10.20.06 Community, local, and state resources
10.20.07 Family counseling
10.20.08 Family consultation
10.20.09 Skill of empathy
10.20.10 Family dynamics
10.20.11 Grieving process
10.20.12 Death and dying
10.20.13 Psychology of aging
10.20.14 Group dynamics

10.30 Task: Plan, implement, and evaluate a food service program designed to meet the dietary needs of patients.

Knowledge of:

10.30.01 Role of Registered Dietician
10.30.02 Proper nutrition
10.30.03 Frequency of meals
10.30.04 Therapeutic diets
10.30.05 Responding to patient satisfaction

10.40 Task: Plan, implement, and evaluate with the Medical Director a program to ensure that patients receive the appropriate medical care.

Knowledge of:

10.40.01 Medical terminology
10.40.02 Physicians' role in the facility
10.40.03 Provision of emergency services
10.40.04 Available physician resources
10.40.05 Physician/patient relationship
10.40.06 Quality assurance

10.50 Task: Plan, implement, and evaluate social recreational and therapeutic recreational activities programs to meet the needs of residents/patients.

Knowledge of:

10.50.01 Community resources
10.50.02 Volunteer equipment
10.50.03 Program evaluation guidelines for activities
10.50.04 Therapeutic recreational needs of patients
10.50.05 Social recreational needs of patients

10.60 Task: Plan, implement, and evaluate an appropriate medical records program for patient care, with consultation.

Knowledge of:

10.60.01 Appropriate medical recordkeeping
10.60.02 Appropriate medical recordkeeping systems
10.60.03 Appropriate charting and documentation

10.70 Task: Plan, implement, and evaluate a pharmaceutical program to support appropriate medical care for residents/patients.

Knowledge of:

10.70.01 Ordering supplies
10.70.02 Proper drug handling
10.70.03 Proper drug storage
10.70.04 Proper drug administration
10.70.05 Proper drug dispensing
10.70.06 Proper drug recordkeeping
10.70.07 Proper drug destruction

10.80 Task: Plan, implement, and evaluate a rehabilitation program that will maintain and/or maximize the potential of residents/patients.

Knowledge of:

10.80.01 Roles of all rehabilitation service disciplines
10.80.02 Community rehabilitation resources
10.80.03 Evaluation mechanisms for determining program success

## 20.00 PERSONNEL MANAGEMENT

20.10 Task: Create a positive atmosphere for communication between management and the work force through receptive management and the use of various media.

Knowledge of:

20.10.01 Establishing grievance procedures
20.10.02 Exit interviews
20.10.03 Analysis of absenteeism and turnover rate
20.10.04 Ways to write informative newsletters
20.10.05 Communication techniques
20.10.06 Interview process
20.10.07 Constructing survey instruments

20.20 Task: Plan, implement, and evaluate a program which will provide an opportunity for the personal growth and development of employees through a performance evaluation process.

Knowledge of:

20.20.01 Constructing rating scales
20.20.02 Techniques for measuring performance
20.20.03 Job requirements of staff positions
20.20.04 Counseling techniques
20.20.05 Establishing job value standards

20.30 Task: Recruit individuals through appropriate referral sources to care for residents/patients directly or to assist in the care of residents/patients.

Knowledge of:

20.30.01 Sources of supply for finding personnel
20.30.02 Writing classified advertisements
20.30.03 Job descriptions
20.30.04 Numbers of positions to be filled
20.30.05 Standards of performance
20.30.06 Ethics of recruitment
20.30.07 Constructing wage scales

20.40 Task: Interview individuals to determine suitability for employment in a nursing home, by means of oral and written techniques.

Knowledge of:

20.40.01 Interview techniques
20.40.02 Good communication skills
20.40.03 Employment documents
20.40.04 Ways to measure applicants' verbal and nonverbal skills
20.40.05 Applicants' health status
20.40.06 Ways in which to stimulate applicant toward employment
20.04.07 Developing accurate job descriptions

20.50 Task: To fill vacancies by selecting prospective staff members from a pool of applicants based upon interview results.

Knowledge of:

20.50.01 Job descriptions
20.50.02 Verification methods of employment history
20.50.03 Ways to ensure that qualifications of candidates are well-matched with the job requirements
20.50.04 Number and type of positions to be filled
20.50.05 Wage and salary negotiations
20.50.06 Identification of employment needs

20.60 Task: Plan, implement, and evaluate a training program to facilitate adjustment of employees to the organization and the job through appropriate educational methodology.

Knowledge of:

20.60.01 Job requirements
20.60.02 Methods to identify areas of weakness to improve employee performance
20.60.03 Teaching techniques
20.60.04 Available training materials
20.60.05 Evaluation techniques of training effectiveness

20.70 Task: Create personnel policies applicable to all employees, to provide a basis for employee conduct and performance.

Knowledge of:

20.70.01 Employee benefits programs
20.70.02 Employee performance standards
20.70.03 Writing clear and concise policies and procedures
20.70.04 Ways to monitor for continued appropriateness
20.70.05 Predicting overall effect on organization

20.80 Task: Plan, implement, and evaluate an employee health and safety program which minimizes the nursing home's exposure to liability through an employee health and safety education program.

Knowledge of:

20.80.01 Insurance coverage
20.80.02 Potential safety hazards and how to correct them
20.80.03 Devising safety incentive programs
20.80.04 Safety rules and procedures

## 30.00 FINANCIAL MANAGEMENT

30.10 Task: Develop an integrated budget for facility to properly allocate fiscal resources, meet regulatory requirements, and provide services at a reasonable cost, using a data collection accounting system and budget format.

Knowledge of:

30.10.01 Generally accepted budget formats
30.10.02 Financial statements
30.10.03 Manpower needs
30.10.04 Census trends
30.10.05 Economic trends
30.10.06 Industry trends
30.10.07 Consumer needs
30.10.08 Competitive services available in community
30.10.09 Facility's capital needs
30.10.10 Regulatory requirements for budgeting
30.10.11 Techniques for determining reasonable costs
30.10.12 Pricing
30.10.13 Need for reserve/profit
30.10.14 Completing an integrated budget

30.20 Task: Plan, implement, and evaluate an integrated financial plan to meet the facility's goals.

Knowledge of:

30.20.01 Planning process
30.20.02 Programs within the facility
30.20.03 Financial resources
30.20.04 Financial ratios
30.20.05 Financial analysis methods
30.20.06 Fixed vs. variable costs
30.20.07 Industry standards
30.20.08 Interpreting financial results for Board and/or appropriate staff

30.30 Task: Develop and/or audit the cash management system to ensure financial viability.

Knowledge of:

30.30.01 Good cash flow procedures
30.30.02 Cash flow needs and trends
30.30.03 Loan acquisition
30.30.04 Insurance needs of the facility
30.30.05 Inventory controls
30.30.06 Banking procedures
30.30.07 Long- or short-term investments
30.30.08 Auditing procedures related to asset management system

30.40 Task: Use generally accepted accounting principles and procedures to ensure accurate financial records.

Knowledge of:

30.40.01 Bookkeeping procedures
30.40.02 Financial reports
30.40.03 Cost reports
30.40.04 Tax reports
30.40.05 Payroll recordkeeping
30.40.06 Regulatory accounting requirements
30.40.07 Collection procedures
30.40.08 Billing procedures
30.40.09 Patient financial screening
30.40.10 Patient banking procedures
30.40.11 Patient account management
30.40.12 Ancillary and other revenue-producing sources
30.40.13 Accounts aging
30.40.14 Assessment methods of accounting system
30.40.15 Purchasing procedures
30.40.16 Comparative pricing
30.40.17 Group purchasing
30.40.18 Material management
30.40.19 Purchase discounts
30.40.20 Accounts payable control system
30.40.21 Payroll procedures
30.40.22 Assessment methods of accounts payable system

## 40.00 MARKETING AND PUBLIC RELATIONS

40.10 Task: Plan, implement, and evaluate a public relations program to inform and educate the public of the positive attributes of the facility.

Knowledge of:

40.10.01 Newsletter construction
40.10.02 Community and social organizations
40.10.03 Need for participating in community functions
40.10.04 Handling media questions
40.10.05 Legislative process and how to use it
40.10.06 Basic public relations principles

40.20 Task: Plan, implement, and evaluate a marketing program to advertise and sell the services of the facility.

Knowledge of:

40.20.01 Newsletter construction
40.20.02 Community and social organizations
40.20.03 Need for participating in community functions
40.20.04 Handling media questions
40.20.05 Legislative process and how to use it
40.20.06 Basic public relations principles

## 50.00 PHYSICAL RESOURCE MANAGEMENT

50.10 Task: Plan, implement, and evaluate a plan for maintenance of building, grounds, and equipment.

Knowledge of:

50.10.01 Preventive maintenance
50.10.02 Availability of equipment and operating manuals
50.10.03 Original blueprints and where they are kept
50.10.04 Environmental design for the elderly and the handicapped

50.20 Task: Plan, implement, and evaluate a program of environmental services which will provide a clean and attractive home for residents/patients.

Knowledge of:

50.20.01 Sanitation procedures
50.20.02 Housekeeping procedures
50.20.03 Infection control
50.20.04 Pest control

50.30 Task: Plan, implement, and evaluate a safety plan which will ensure the health, welfare, and safety of residents/patients, staff, and visitors.

Knowledge of:

50.30.01 Safety codes
50.30.02 Potential hazards
50.30.03 Proper and adequate lighting
50.30.04 Safe housekeeping procedures
50.30.05 Safety devices
50.30.06 Security measures

50.40 Task: Plan, implement, and evaluate a fire and disaster plan to protect the safety and welfare of residents/patients, staff, and property.

Knowledge of:

50.40.01 Assessing staff to assign responsibility for specific duties
50.40.02 NFPA guidelines
50.40.03 Community emergency resources
50.40.04 In-house emergency equipment
50.40.05 Training resources
50.40.06 Evacuation resources

## 60.00 LAWS, REGULATORY CODES, GOVERNING BOARDS

60.10 *Task*: Plan, implement, and evaluate policies and procedures which are in compliance with federal laws and regulations.

*Knowledge of*:

| | |
|---|---|
| 60.10.01 | Medicare and Medicaid |
| 60.10.02 | Labor laws |
| 60.10.03 | Life safety |
| 60.10.04 | Building codes |
| 60.10.05 | OSHA |
| 60.10.06 | HCFA rules |
| 60.10.07 | Civil Rights laws |
| 60.10.08 | Resident Bill of Rights |
| 60.10.09 | Tax laws (proprietary and nonprofit) |
| 60.10.10 | Legislative process |
| 60.10.11 | Licensing and certification |
| 60.10.12 | Ombudsman function |
| 60.10.13 | Professional licensing boards |

60.20 *Task*: Plan, implement, and evaluate policies and procedures which are in compliance with directives of governing board.

*Knowledge of*:

| | |
|---|---|
| 60.20.01 | By-laws |
| 60.20.02 | Directives generated by Board |
| 60.20.03 | Responsibilities to the Board |
| 60.20.04 | Legal aspects of the corporation |
| 60.20.05 | The governing board and its organization |

EXHIBIT B

(Policy Statement)

## ADMINISTRATOR-IN-TRAINING PROGRAM

It is the policy of Virginia Board of Examiners for Nursing Home Administrators to establish a continuous administrator-in-training program for the purpose of training responsible individuals to become qualified nursing home administrators.

This program will extend over a period of twelve months, and not more than 24 months and will consist of both academic and residency training in a long term care facility. The program is divided into three phases. The first phase consists of twenty-six weeks of residency training in a nursing home. Each home will be an approved training site with particular emphasis on the competency and high ethical standards of the preceptor, and the size and complexity of the facility.

The second phase will orient the trainee to the functioning and operations of a nursing home. It will include a total of six weeks of hands on training in accounting, fiscal, and personnel matters, in addition to ten weeks of training with various support services and operations consultants.

The final phase of the program consists of two four week terms as assistant to the administrator where the trainee will have the opportunity to utilize his leadership skills while still under supervision and instruction. The final two weeks of this phase are spent achieving additional exposure to the long term care industry.

In order for a candidate to be accepted into the administrator-in-training program, certain established criteria and qualifications must be met. The applicant shall be at least twenty-one years of age.

Each trainee will be required to submit a monthly report, to a qualified preceptor, indicating what areas of learning have been covered during the previous month of training, together with an assessment thereof. In addition, the trainee will keep a daily journal of progress, to be used for reference and as an aid to the preceptor in planning the program's curriculum.

The training program will be individually adapted, depending on the trainee's prior knowledge and experience in health care and/or business administration. Planned conferences and open communication patterns will be established between trainee and preceptor, in order to promote an atmosphere of questioning and learning. At the conclusion of specified stages of training, the preceptor will prepare an evaluation of the trainee's performance, to be shared and discussed with him, at which time further specific objectives will be provided as a basis for assessment.

## STATEMENT OF NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.

The National Association of Social Workers (NASW) represents 105,000 members and is dedicated to improving social conditions and the lives of individuals and families in this country. As such, NASW is supportive of consideration being given by Chairman Waxman of the Health and Environment Subcommittee and by others in the 100th Congress to improve the quality of care provided to nursing home residents. Our testimony is focused on the psychosocial needs of nursing home residents and overcoming barriers to meeting those needs. NASW is particularly pleased that HR. 2270, the "Medicaid Nursing Home Quality Care Amendments of 1987", recognizes the importance of nursing homes meeting residents' mental and psychosocial needs, needs that are sometimes inadequately addressed in long-term care facilities.

Individuals living in nursing homes face a variety of emotional and social stresses which affect their quality of life and their ability to function at an optimal level. These psychosocial stresses may interfere with the resident's medical treatment plan. Separation from family and other loved ones, a radically altered personal living situation, isolation from community resources, financial stress, an alien living environment, and emotional or mental problems that sometimes accompany the aging process itself are just some of the realities with which they must contend. It is estimated that close to two-thirds of all nursing home residents have a diagnosed mental disorder. With hospitals discharging patients "sicker and sooner" to comply with DRG regulations, more individuals with greater medical and psychosocial needs find themselves looking to long-term care facilities as alternative living situations.

## SOCIAL WORK SERVICES IN THE NURSING HOME

The role of the social worker in a nursing home is to provide services designed to identify and meet the social and emotional needs of each resident; to assist each resident and their family to adjust to the effects of their illness or disability, treatment, and stay in the facility; to maintain or establish appropriate linkages for residents to community social and health resources; and to assure adequate discharge planning. Specific social work service functions in a nursing home generally include, but are not limited to:

- direct counseling services to residents, families and groups at the time of admission and throughout the placement as required;
- advocacy;
- community liaison and linkage to services;
- development of a therapeutic environment in the facility;
- consultation to members of the health care team;
- working with resident and/or family councils;
- securing resources and working with community volunteers and other community agencies and organizations;
- participation in policy development and program planning;
- discharge planning.

Social work services can offer an improved quality of life for residents and can contribute to a facility's work to contain costs. "Qualified social workers deliver social services in a manner that is effective for residents and that, in the long run, is also cost effective," according to Jenean Erickson, Administrator of the Yorkshire Manor Nursing Home in Minneapolis, Minnesota. Ms. Erickson, a nurse by training, employs professional social workers to deliver social services in her facility.

Data suggest that people under emotional stresses are higher users of medical treatment than others. Social workers in nursing homes are in critical positions to help ease those emotional stresses and thereby, reduce medical costs. As an American Psychological Association summary of a Kaiser-Permanente study (Cummings and VandenBos, 1981, Health Policy Quarterly, p. 1) reports:

> A series of studies have been conducted since the inception of mental health care coverage, and all concluded that psychological intervention can be cost effective by saving on medical costs and therapeutically effective.

## CURRENT BARRIERS TO THE EFFECTIVE DELIVERY OF SOCIAL SERVICES

Despite the critical need for the effective delivery of social work services in nursing homes, a large number of residents are not receiving those services. The major obstacle is the lack of strong requirements. The result as documented by the Institute of Medicine's 1986 Report Improving the Quality of Care in Nursing Homes, is uneven and inadequate availability of social services.

The current social service condition of participation for a skilled nursing facility allows the facility to either refer patients in need of social services to outside social agencies or to offer the services in the nursing home. If services are offered in the nursing home, a designated staff person is responsible for social services. The designee is required only to consult with a qualified social worker or social agency. The Institute of Medicine's report found:

> Reliance on this weak requirement has produced uneven results at best. Studies in various parts of the country show that many facilities have a bare minimum of social services--that is, they hire an MSW for 4 hours per month of consultation and appoint designees who are less than full-time and have little professional or even general education. Studies of the consultant role have shown how difficult it is for a nursing home consultant to design a social work program, develop procedures for a socially and psychologically sensitive environment, train and supervise service designees, and design and conduct in-service training for all nursing home staff, given the minimal time allotted to their role and their negligible authority as a consultant.

The State of Texas Long Term Care Coordinating Council for the Elderly (comprised of representatives of the nursing home industry, consumers, educators and Texas Department of Health staff,) concurred in their March 25, 1987 issue paper, Social and Emotional Needs of Residents of Texas Nursing Homes, that social services staffing patterns are often inadequate. After reviewing social work treatment concepts in nursing homes, they found:

> It is also clear that, when considered in the context of Texas nursing homes, most models cannot be fully articulated due to parsimonious funding and the lack of qualified professional staff. Without qualified staff's knowledge and skills in treatment program design and delivery, a limited repertoire of approaches, the proverbial activities of bingo, Bible, and birthday parties, are offered to the many and slightly enriched, but still meager treatment menu consisting primarily of psychotropic medications is offered to the few with extreme behavior problems or strident needs. The exception may be the situation that obtains in a small number of non-profit nursing homes that employ sufficient, qualified social service staff.

## RECOMMENDATIONS

To eliminate barriers to the effective delivery of social work services in nursing homes in order to enhance quality of life for residents, in a cost effective manner, NASW recommends that:

- o Each long-term care facility with 80 beds or more be required to employ at least one full-time professionally qualified social worker per 80 beds to assure the provision of appropriate social services.
- o Each long-term care facility provide social services which include at least: planning for preadmission and discharge; providing psychosocial assessment at period intervals; care planning; counseling and other psychotherapeutic services; developing and utilizing community resources (care coordination); assisting in the preservation of family and other social

relationships; promoting visitation to residents; maintaining community ties; working with other nursing home staff to facilitate residents' adjustment to the facility advocating for residents' rights; and promoting understanding of each resident as an individual.

## CONCLUSION

NASW commends Representatives Dingell and Waxman and their colleagues for their work to improve the quality of care in nursing homes. It is essential, as included in HR 2270, that nursing homes use qualified providers for delivering social services to meet physical, mental, and psychosocial needs of each resident and that meeting those needs be a requirement for each facility. The use of qualified personnel can mean the difference between quality and inadequate social services for nursing home residents. For this reason social workers urge Congress to pass legislation that ensures that residents' psychosocial needs are addressed by professional social workers, not untrained social services "designees." Improvements such as these are critical if we as a society want to see all individuals in nursing homes actually receive the quality care they deserve.

STATEMENT OF
FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN
NATIONAL COMMITTEE
TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, my name is James Roosevelt and I am the Chairman of the National Committee to preserve Social Security and Medicare. In that capacity, I represent more than four million members, most of whom are age 65 and older. Over the last few years, I have received hundreds of letters from seniors documenting nursing home abuses and calling for nursing home reform. Today I am releasing a report, Please Don't Publish My Name: A Call for Nursing Home Reform, which is based on these letters from relatives and friends of nursing home residents, residents themselves and a few former and present nursing home employees.

Nursing home residents are one of the most vulnerable segments of our society. That is why members so often begged us not to publish their names, for fear of retaliation. Many members expressed helplessness, hopelessness and bitterness. One woman, referring to her sister, writes, "She was let out to come home, at her own request, and committed suicide rather than go back. I plan to do the same thing when my time comes." Another simply wrote, "I, too, will end it all before I go back to one."

A Woodland Hills, California, woman wrote a list of nine cases of neglect and abuse that her husband had suffered in a nursing home. For example, "The aide taking care of him punched him on the head (where it wouldn't show) because the aide assumed my husband had removed his catheter and now the aide had to change the bed." Another example: "My husband could not feed himself due to paralysis from a stroke; the aide shoved food into his mouth so fast my husband couldn't swallow or chew it, and after choking several times, refused to eat."

The humanity of our society will be judged by the way we treat the most vulnerable in our society. Over 1.5 million seniors currently reside in nursing homes. While this is only 5 percent of older Americans, 20 percent of older Americans are at risk of needing nursing home care sometime before they die. The burden of care has overwhelmed the private capacity of families to care for their loved ones at home or to pay for nursing home care. Society must help with this burden. And to the extent that government pays for nursing home care, it has the responsibility to guarantee a high quality of nursing home care.

Unfortunately, the federal government has neglected its responsibility to ensure that nursing home residents receive quality care. The government has been reluctant to use all of its possible weapons, especially effective enforcement measures. Except for an underfunded ombudsman program, the government has given senior citizens and their families little assistance in finding a good nursing home and protecting their rights. It almost appears that Medicaid and Medicare condone neglect and abuse in our nation's nursing homes.

In response to the concerns raised by our members, the National Committee developed a five point plan calling for:

1) strong federal penalties;
2) quality of care surveys;
3) effective training of nursing home personnel;
4) a stronger Long-Term Care Ombudsman Program; and

5) a rating system to help consumers select a good facility.

These five points offer a broad outline to revamp the nursing home industry in a way that would be more responsive to the needs of residents and their families. Last year, you heard from tens of thousands of National Committee members who wrote to Congress asking for support of our five point plan.

The Institute of Medicine last year released a report, Improving the Quality of Care in Nursing Homes. The report confirms widespread nursing home abuses and makes a number of recommendations for nursing home reform. Too often, however, government-sponsored reports gather dust and no one takes action. National Committee members are committed to seeing that this does not happen.

In addition to the National Committee's five point plan, we have collaborated with the National Citizen's Coalition for Nursing Home Reform and other national organizations in the development of 12 position papers primarily based on recommendations from the Institute of Medicine study. We presented these recommendations to Congress in a press conference last month. These position papers more fully detail our legislative recommendations and advocate a prohibition of discrimination against Medicaid patients and the promotion of social and mental health services. We urge you to implement these recommendations.

I know, Mr. Chairman, that you care deeply about the health and welfare of America's senior citizens and we particularly commend you for your efforts to improve nursing home conditions. We support H.R. 2270, legislation which you introduced with Chairman Dingell, Congressman Stark and Congressman Pepper. I hope that other Members of Congress will support your legislation to ensure that the care that the frail elderly receive in nursing homes will be of the highest quality. With a doubling of the nursing home population in the next twenty years, the problem will only grow worse, unless Congress acts now.

Thank you.

## PLEASE DON'T PUBLISH MY NAME: A CALL FOR NURSING HOME REFORM

One of the most vulnerable and powerless segments of American society is the 1.5 million older Americans who now live in nursing homes. One-third of this population group is over 85 years old. Two-thirds of these residents either entered the nursing home as welfare recipients or now receive welfare because the cost of nursing home care has bankrupted them. Nine out of ten are widowed, divorced or never married. Half of these residents have Alzheimer's disease and half have either heart disease, hypertension, and/or arthritis. Most have multiple chronic illnesses.[1]

In September, 1985, the House Select Committee on Aging's Subcommittee on Health and Long-term Care found that the rights of most nursing home patients are violated daily. The Subcommittee also found that 75 percent may be denied the basic right to complain and seek redress of grievances without fear of retribution, while 70 percent may be denied the right to make choices about what and when to eat and when to sleep and when to wake. Also, 45 percent may be denied the right to maintain personal possessions, 35 percent may be denied adequate and appropriate medical and nursing care, and 15 percent may be subjected to physical and sexual abuse.[2]

Of the 15,000 nursing homes presently in operation, one-third are substandard[3] and 10 to 15 percent offer care which is chronically substandard.[4] In spite of this, only 32 of these 15,000 homes were closed in 1984 because of violations of federal certification standards. Most of those reopened within weeks. In fiscal year 1987 the federal government will spend only approximately 0.5 percent of its nursing home budget on enforcement of federal certification standards.[5]

## MEMBER SURVEY PROJECT

In an effort to gain detailed information on the state of nursing homes, James Roosevelt, chairman of the National Committee to Preserve Social Security and Medicare, requested National Committee members to describe, in writing, first-hand experiences of nursing home abuse. Hundreds of members from all parts of the country responded. Most of the respondents were relatives of nursing home residents, although some actual residents also responded (as did some former and present nursing home employees).

Excerpts from the letters will be used freely, but selectively, in this report. The reader, no doubt, will find these letters unpleasant, even shocking and perhaps depressing. However, the purpose of using these letters is to put a human face on a problem which has too often been sanitized by the sterile jargon of academic reports and Congressional resolutions. There is, of course, a great need for such reports but an even greater need for Congressional action. This report is a call for action, by highlighting the human side of the issue.

From these letters one clear and uniform impression emerged: The quality of care provided in nursing homes is often poorest in areas of basic and reasonable human needs -- needs which can be met simply through the exercise of common courtesy and greater attention to detail on the part of staff. For instance, respondents often complained of such things as not being able to reach drinking water, room temperature being too hot or too cold, or a radio played in spite of constant requests that it be turned off.

The friend of one nursing home resident writes, "They (the patients) weren't given a carafe of cold water, even on a hot summer day, because they got something to drink with their meals. Our little friend was treated roughly and told she was a cry baby and a pest." One nursing home resident writes indignantly, "I am 94 years old, a resident 'inmate' in a nursing home. (I get) inadequate nutrition because of lack of interest. I require soft bland foods. I get chicken legs, which I can't eat because of lack of teeth and sore mouth, gums and tongue. Sometimes (I eat) almost nothing."

Upon reading these letters one cannot help being struck by the unmistakable sense of helplessness, hopelessness and bitterness on the part of nursing home residents and their families. This is poignantly reflected by the number of times our members requested, "Please don't publish my name." They went on to explain, "I may have to go there someday too" or "They know me . . . and Mother will suffer."[6]

The frequency and poignancy of this request lends a certain urgency to the call for action from our members. Even more urgent is the call reinforced by letters which mention suicide. One member, referring to her sister, writes, "She was let out to come home, at her own request, and committed suicide rather than go back. I plan to do the same thing when my time comes."

Another respondent simply states, "I, too, will end it all before I go back to one."

There are other, more general, characteristics of nursing home life which emerge from these letters. One characteristic is that those who need the most care, ironically, often receive the least amount of attention. The ever present despair in these letters is understandable when basic needs and reasonable requests go unattended.

One letter states matter-of-factly, "I can't think of anything worse than having a 'nature' call and no one coming to assist. Then when the 'worst' happens, having to lie in my own waste for hours. Also these poor souls are tied in wheel chairs from morning until night and must sit in their own waste and sleep in a very uncomfortable position."

Judging from the letters, it is not uncommon for patients to receive as much or more attention from family members than from the nursing home's staff. A respondent from Texas writes, "I furnish my wife soap, lotion, shampoo, and more than half her food. I spend no less than six hours a day with her. I feed her and give her therapy (arms, legs, etc.). I have fed her three meals a day most of the last three years."[7]

Another respondent, who says she now has a "horror" of being placed in a nursing home after seeing the way her mother was treated in one, writes, "I can't imagine what care she'd gotten if I hadn't come every day until 6 p.m." Later in the same letter she writes, "She was in constant pain, but would run out of her pain pills. I had to carry some in my purse and often times would have to call the doctor and get them myself."

The more common health-related complaints concern bed sores, dehydration, and lack of exercise. Not surprisingly, the more common complaints of a non health-related nature are of staff indifference and lack of expertise. Still another complaint is that stealing, primarily by staff but also by other patients, is common.

Not all nursing homes provide inadequate care; in fact, some homes provide excellent care.[8] The ones which provide excellent care, however, are the exception, not the rule, and frequently they will not accept Medicaid patients.

In response to the concerns of our members, as illustrated by their letters, the National Committee proposes a five-point plan to help meet the needs of nursing home residents. Each of these five points concerns a specific area of nursing home operation, which is in urgent need of reform. In its entirety, the five point plan, if implemented, would constitute a major revamping of the nursing home industry in a way that would make it more responsive to the needs of residents and their families. National Committee members highlight with examples why each of these points is important to a comprehensive nursing home reform plan. The National Committee considers these five points to be broad standards by which nursing home reform should be judged.

## FIVE-POINT PLAN

1. **INITIATE QUALITY OF CARE SURVEYS, INSTEAD OF JUST COUNTING NUMBERS OF STAFF AND KINDS OF FACILITIES.**

2. **IMPOSE FEDERAL PENALTIES WITH REAL TEETH IN THEM TO FORCE NURSING HOMES TO CORRECT ABUSES.**

3. **REQUIRE EFFECTIVE TRAINING OF NURSING HOME PERSONNEL AND REGULATORS.**

4. **STRENGTHEN THE OMBUDSMAN PROGRAM TO HELP RESIDENTS, FAMILY OR FRIENDS CORRECT ABUSES IMMEDIATELY WITHOUT FEAR OF RETALIATION.**

5. **INSTITUTE A RATING SYSTEM TO HELP THE ELDERLY CHOOSE A GOOD NURSING HOME.**

## INITIATE QUALITY OF CARE SURVEYS, INSTEAD OF JUST COUNTING NUMBERS OF STAFF AND KINDS OF FACILITIES:

> "When they are expecting the state people, they have everything cleaned and get rid of the odor."
>
> \- Daughter of a
> nursing home resident

Unlike survey and certification regulations of the past, the focus of any future government survey process should be on evaluating the quality of services actually provided, not simply estimating the facility's capacity to provide required services. Without an adequate evaluation of the quality of care actually being delivered, it would be impossible or useless to implement any nursing home reform plan.

One respondent offers a possible solution: "Inspectors should go to those nursing homes - pose as a relative and check around and spend an hour or so with someone. Press the button on the bed and see how long it takes for a nurse to come in. They'll learn a lot in a short time." Alternatively, inspectors could learn a great deal about the quality of care simply by listening to the nursing home patients and family members, just as the National Committee has learned a great deal through its member project.

As noted above, many of the letters the National Committee received from its members exhibited an unmistakable bitterness. This bitterness was sometimes caused by the inadequacy of the inspection system in the nursing home industry. One reason cited for inadequate inspections is that nursing homes frequently receive advance notice. One respondent writes, indignantly, "Why should a home be notified that an inspection is coming? They say they don't know when the state will come. But believe me if you could see the cleaning going on a few days before an inspection, you would know better."

Quality of care should be measured through a standardized assessment tool which focuses on key quality indicators. This tool should be developed by the Health Care Financing Administration (HCFA). Surveyor qualifications should be determined by federal guidelines and there should be an increased federal role in the training of personnel who will administer the surveys. There should also be increased federal involvement in the inspection process. Also, the Medicare and Medicaid survey and certification process requirements should be combined.

## IMPOSE FEDERAL PENALTIES WITH REAL TEETH IN THEM TO FORCE NURSING HOMES TO CORRECT ABUSES:

> "In our area many people have tried to better conditions at our local nursing home, but to no avail."
>
> - Friend of
> nursing home residents

Many of the respondents in our survey expressed disillusionment at the government's ineffectiveness in monitoring nursing homes. This disillusionment was often expressed by citing the many contributions they had made to society throughout their lives as workers, taxpayers and soldiers. In general, respondents could not believe that the federal government spends billions of dollars on nursing homes through Medicare and Medicaid, yet gets such a small return on its investment in terms of quality of care. One respondent wrote, "It is your tax money and mine, Mr. Roosevelt, that is paying for this treatment of our sick and elderly. Right here in our own country are the most neglected and abused people in the world and we are condoning it through government funds."

At present, nursing homes have little incentive to change their "business as usual" attitude because the federal government fails to effectively enforce the standards already set forth in the law. In addition, it is clear additional sanctions are necessary. One sanction which would effectively motivate nursing home operators to make immediate corrections of deficiencies is the imposition of civil fines within a week of the discovery of a deficiency. The amount of the fine would depend on the nature of the deficiency but the nursing home would be required to pay it within five working days. If, upon appeal, the fine is determined to be unwarranted, the money would be returned to the operator. Fines imposed at the time of infraction not only correct the deficiency, they also greatly reduce the chance of recurrence.

The time factor is an important feature of effective enforcement and applies to other sanctions as well. A case in point is the recently implemented government sanction which bans new admissions until the substandard care is improved. This sanction does not give a nursing home incentive to maintain high quality of care because the nursing home is given several months to correct the problems before the ban on admissions is implemented. Consequently, this sanction does not insure that the improvements are either immediate or permanent.

The National Committee supports a ban on admissions to nursing homes that provide substandard care, but feels the ban would be more effective if implemented much quicker after the time an infraction is cited. As with the case of civil fines imposed within a week of when the deficiency is found, the burden of responsibility to prove that the care meets the standards lies with the nursing homes.

Another sanction supported by the National Committee is placing a nursing home in receivership when chronic substandard care is exposed. In the past, the only recourse open to the government in its efforts to insure high quality care was closing the home. This was rarely done because it would force the residents to find a new home. Placing a nursing home in a government-managed receivership, however, would strengthen the government's enforcement efforts without making patients suffer.

These sanctions could be imposed separately or simultaneously, as the situation dictates. They would shift the responsiblity for providing quality care to the nursing home and would, therefore, provide nursing homes with more incentive to change their "business as usual" attitude. It may also be necessary for the federal government to more closely monitor the performance of state agencies which perform the nursing home surveys and levy the sanctions.

## REQUIRE EFFECTIVE TRAINING OF NURSING HOME PERSONNEL AND REGULATORS:

> "Employees not properly trained to handle patients with a mechanical lift dropped her twice - once from almost three feet, head first on the tile floor. It took three stitches to close the bursted scalp. The other time, I saw it coming and threw my arms and legs under her to break the fall."
>
> - Husband of a nursing home
> resident (Name Withheld)

Quality of nursing home care depends on competent and caring personnel. Too many respondents said they suffered from the inexperience and neglect of nursing home personnel. One woman described her father's situation: "He took Valium for his nerves. I would ask the nurse to give him one, but the nurse would laugh and say she was going to take one first. He never got one. He would beg for water at night, but received no water till we visited. He was getting worse instead of better."

The vast majority of care given in nursing homes is given by nurses' aides.[9] Yet, a qualifying examination for nurses' aides is required in only 17 states. This deplorable situation can only be rectified by establishing a comprehensive and mandatory training program, with guidelines, curricula, and requirements designed by the federal government. This would insure uniform implementation throughout the states.

Our members proved themselves to be very astute in understanding what the problems are in training competent nurses' aides. As one member writes, "I know these aides get minimum wages. As soon as they find something better, they leave. These aides are the contacts with these poor souls - yet there are always new faces, instead of familiar, caring ones." In general, benefits are equally unattractive; the job is held in low esteem, there is very limited career mobility, and the work itself is very difficult. In order to create incentives for people to become nurses' aides, the National Committee believes it is imperative that personnel policy, including wages and benefits, be greatly upgraded to reflect the quality of work desired.

In order to develop and implement an effective survey system and to ensure the enforcement of strict penalties for violation of certification standards, proper training of the personnel engaged in these inspection activities is also essential. The federal government must pay for the full cost of this training.

## STRENGTHEN THE OMBUDSMAN PROGRAM TO HELP RESIDENTS, FAMILY OR FRIENDS CORRECT ABUSES IMMEDIATELY WITHOUT FEAR OF RETALIATION:

> "I knew they were abusive but I didn't know where to turn. I was afraid that if I complained too much they would treat him even worse."
>
> - Wife of a nursing home resident (name withheld because, "I may have to go there someday too.")

Our members continually expressed frustration at their inability to have abuses investigated and corrected. As the title of this report suggests, their frustration often was accompanied by a fear of reprisal for speaking out. Some respondents complained about the work of their particular ombudsman and others criticized their local agencies for the elderly. One woman writes, "Approximately fifteen families contacted the office of Aging, the Ombudsman Program and the Medical Director for the state . . . . The Office of Aging, a superfluous agency in our minds, advises that we must have proof of allegations pointed out to them. How can you have proof of people sitting tied in chairs for hours, rodents, no water, dirty beds and clothing, shortage of personnel, etc., when the inspector overlooks or does not see these conditions?" [10]

The role of the ombudsman in the delivery of quality care is critical. There are a number of recommendations which, if enacted, would strengthen the ombudsman program. Underlying these recommendations, as with the recommendations cited above, is the need for increased involvement of the federal government in providing training and technical assistance for ombudsman. Each ombudsman must have free and unhindered access to all facilities, residents, and records deemed necessary for proper patient care. Ombudsman liability for actions should be removed and ombudsmen should be able to trigger an official investigation of a nursing home.

Also, nursing home residents should be allowed a private right of action. Abuse which is criminally negligent should be legally actionable. Nursing homes which offer substandard care should be held accountable for their negligence. There can be no compromise on accountability and no substitute for it.

## INSTITUTE A RATING SYSTEM TO HELP THE ELDERLY CHOOSE A GOOD NURSING HOME:

> "Had I known about the Nursing Home Advocates and called them back in 1985, I never would have placed my mother in your care."
>
> - Letter to the administrator
> of a nursing home that
> provided substandard care

Many of our members complained that they were under the mistaken impression that the home they placed their relatives in was one of the better homes in their area. This was a recurring source of frustration among respondents. One letter begins, "My husband was in what was considered a 'better' nursing home for six months. It was the most miserable experience both of us ever had." Another letter ends, "I would leave here but doubt if I could better myself. I have been told this is the best in the city."

In his testimony before the House Select Committee on Aging's Subcommittee on Health and Long-Term Care in September, 1985, Neil F. Hartigan, Attorney General of Illinois, called for the establishment of a national rating guide to help consumers choose an adequate nursing home. Mr. Hartigan told the subcommittee, "Examples of information to be included in the national rating guide could be the number of license revocations in each state, the number of criminal prosecutions for abuse and neglect, the number of nursing homes fined for fraud and abuse of government funds, the number of Medicaid fraud unit prosecutions for patient abuse and neglect."[11]

Aside from information about a particular nursing home in relation to its legal history, a rating system should provide information on the quality of care available in the home. The standardized assessment tool to be developed by HCFA could provide the basis for this part of a rating system.

Rating systems instituted in individual states thus far have met with limited success. This has caused some nursing home reform advocates to question the feasibility of rating nursing homes. However, the National Committee believes that greater success can reasonably be expected if the rating system is national and uniform. The National Committee endorses a rating system as a long-term goal.

## CONCLUSION

The need for effective and comprehensive nursing home reform is critical and immediate. The problem is not solely an issue for older people. It affects all age groups. One sobering demographic trend shows that the nursing home population will double in the next twenty years. Consequently, unless reforms are made now, the situation could only get progressively worse. The Institute of Medicine's (IOM) report, The Quality of Care in Nursing Homes, is a broad confirmation of the problem. The reform suggestions made in this comprehensive study generally parallel the National Committee's proposal and help focus attention on the issue. Legislative activity at the end of the 99th Congress is a good omen for the 100th Congress. Reform legislation introduced by Representatives Claude Pepper, Henry Waxman, and Olympia Snowe, as well as legislation introduced by Senators John Heinz and William Cohen, are good starting points for reform initiatives in the 100th Congress.

The National Committee would like to see this report, along with the IOM study and the legislative activity that has already taken place, serve as a springboard for meaningful nursing home reform. Without action, the abuses will continue. The sad but indisputable fact is that people are dying of indifference and neglect every day. Their only crime is that they are old and unable to stop such abuses by themselves. The only hope for these people (and for ourselves if we are unfortunate enough to be placed in a substandard nursing home in the future) is that their call for help is heard and acted upon. One respondent ended his letter simply, "Something just has to be done."

It is appropriate to end this report by quoting, once again, from one of our member's letters. In this letter the respondent said the painful memories brought back by writing were such that it took her a few days just to be able to pick up a pen to recount her mothers' nursing home story. After describing her shock at finding that the home she had believed to be "one of the better ones" was substandard, she concluded:

> "Personal articles were stolen or used indiscriminately by anyone who was near. Often I found my mother's hairbrushes, which I replaced frequently, in a roommate's drawer (who was bedfast) full of different colored hair. Once when I was cleaning her dentures I saw a roach crawling in her denture cup. But they finally lost both of her dentures, so she was relegated to baby food.
>
> There's more, but I can't bear to go on."

## FOOTNOTES

1. Hearing Before the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging (September 19, 1985), p. 3-5.

2. Ibid.

3. Senate Special Committee on Aging, Nursing Home Care: The Unfinished Agenda (May 1986), p. 3.

4. Committee on Nursing Home Reform Regulation, Institute of Medicine, Improving The Quality of Care In Nursing Homes (Washington, D.C. National Academy Press 1986), p. 149.

5. The combined Medicaid expenditures of the federal government for fiscal year 1987 for Skilled Nursing Facilities (SNF's) and Intermediate Care Facilities (ICF's) is approximately $7.5 billion. Of that amount, approximately $38 million will be spent on nursing home inspection, which is roughly 0.5%. Aside from providing for the actual annual inspection of homes already in operation, the initial inspection of new homes, and follow-up inspections, this amount also includes attendant costs of the inspection process. These costs include providing cost-of-living-adjustments for the salaries of the surveyors, assuring that adequate staffing levels are maintained, and funding for training courses for attendants. This information was provided by Jeff Clarke of the Health Standards and Quality Bureau of the Health Care Financing Administration in a telephone interview on June 23, 1986.

6. The names of respondents who would allow their names to be published are available upon request.

7. This situation is particularly disturbing when considering the cost-effectiveness of Medicaid expenditures. For instance, federal Medicaid expenditures per nursing home patient in SNF's and ICF's is approximately $4,600 annually ($7 billion divided by 1.5 million patients). Looked at another way, the federal government, through Medicaid, pays

approximately $20,000,000 per day to SNF's and ICF's ($7 billion divided by 365 days). As will be shown later in this report, our members expressed a marked frustration over how much is paid to nursing homes through government funds and the quality of services that is delivered. As these figures show, there is a mathematical basis for this frustration.

8. Three of the letters we received spoke in positive terms about nursing homes. The writer of one letter warned against using horror stories because it tends to make seniors afraid to consider using a nursing home for themselves or a loved one. We are aware of this possibility and sensitive to it. Our intention is not to scare anybody, much less senior citizens. It is to try to generate Congressional action, as called for by our members, which will reform the nursing home industry in order to make it more responsive to the needs of nursing home patients and their families.

The good and excellent nursing homes which consistently meet government standards and which provide a caring and humane environment for their patients should be commended. Such homes are not the subject of this report.

9. A survey conducted by the National Citizens' Coalition for Nursing Home Reform in 1984 of over 400 nursing homes nationally, found that residents viewed workers as the most important factor affecting nursing home care. According to NCCNHR, nurses' aides provide 90% of the direct care nursing home residents receive. Nursing Home Workers, a fact sheet prepared by the National Citizens' Coalition for Nursing Home Reform, March 1986.

10. This letter was accompanied by a letter sent to the owner of the nursing home where her husband died. It included a list of 20 substandard conditions which exist in the home as well as a complaint about the indignity of receiving a bill for her husband's care on the day of his burial. She concluded her letter to the owner in the following way " -- you will never have to answer to me, any resident or family member for the conditions you are apparently condoning at the Nursing Home, but there is a higher authority to which you will answer in some way."

11. Hearing before the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging (September 18, 1985), p. 60.

Association of Health Facility Licensure and Certification Directors

May 21, 1987

The Honorable Henry Waxman
Chairman
Subcommittee on Health and Environment
House Commerce Committee
U.S. House of Representatives
2424 Rayburn Building
Washington, D. C. 20515

Dear Representative Waxman:

The Association of Health Facility Licensing and Certification Directors represents the individual state agencies responsible for the survey and certification of Medicare and Medicaid nursing care facilities. For the past 20 years we have employed professional staff to conduct inspections of the country's Medicare and/or Medicaid certified nursing homes in accordance with established Federal criteria. Based on our long experience in this program, we welcome this opportunity to provide written comments on HR 2270 which we feel represents a timely, necessary and important evoluntionary step that will give a new sense of direction and purpose for the manner in which we assure that quality health care services are available to our citizens in need of nursing home services. Our organization has participated in and closely followed the activities of the Institute of Medicine Committee that made many of the recommendations that are incorporated into this House Resolution. While we strongly endorse most of the provisions of this bill, we are persuaded that certain additional comments are in order and are hereby offered for your consideration.

We support the concept relating to the preadmission screening and review for mentally ill and mentally retarded residents to assure that they will receive reasonably appropriate placement in a health care setting designed to meet their needs. However, we strongly urge the Subcommittee to reconsider the discriminatory manner in which FFP would be denied for certain services on behalf of such persons. If mentally ill or mentally retarded individuals need certain active treatment services, we feel there should be a federal contribution for the provision of those services if that individual otherwise qualifies for or needs the nursing services associated with a nursing care facility. To further assist us in the matter of conducting preadmission reviews of mentally retarded and mentally ill individuals, we recommend that the Secretary be required to publish specific criteria for screening these individuals and that there be a sufficient public comment period on the proposed criteria prior to their final promulgation.

We support the bill's intent to increase the availability of licensed nursing personnel in all nursing care facilities. We believe this course of action is properly responsive to the changing characteristics of nursing home admissions affected in large part by the Prospective Payment System that governs Medicare hospital reimbursement activities and, is sensitive to the increasingly limited availability of registered professional nurses to provide direct care services in a variety of health care settings.

We strongly object to the position taken by the Health Care Financing Administration that the majority of the contents of the bill can be accomplished without statutory changes but through the Secretary's authority to promulgate regulations beyond those already included in the statute. Our past experiences have demonstrated a marked reluctance or unwillingness on the part of HCFA to undertake timely regulatory change and our recent experience with the implementation of the new long term care survey process reinforces that belief. We noted that the new survey process represented the greatest change in the way nursing homes are surveyed that had occurred in the last twenty years. Such a drastic change was accomplished, via fiat, and without an open public comment period that provided the opportunity for meaningful input. As a result, we are working with a system that is significantly flawed and has recently been the subject of an adverse determination by a federal court. We believe that the Congress needs to give the Secretary specific statutory direction in the matter of nursing home regulatory standards. Since HR 2270 will be charting the course for the future, we feel that those areas wherein the Secretary is charged to establish guidelines, standards and criteria must only be done through a very open and public process wherein public comments can be submitted and must be considered before final determinations are made. We feel it most appropriate if such determinations are made through the rule making process with proper publication in the Federal Register. Failure to provide such a process only invites the development of administrative directives that are not sensitive or responsive to the many years of experience that our members have from being direct, on-site surveyors and regulators of nursing care facilities.

We strongly support the concept of standard and extended surveys assuming that suitable survey protocols will have been developed. However, we are concerned with the requirement that each nursing facility would be subject to an unannounced standard survey no more frequently than every nine months and no less frequently than every 15 months. Under certain circumstances, it may be appropriate, based upon information known to the state survey agency, to do an unannounced survey earlier than nine months from the last such survey. In our experience, complaints filed with state survey agencies often identify and trigger the need for a survey of the facility that is not limited to the investigation of the complaint itself. In addition, we are concerned with the requirement that a standard survey would have to be conducted within two months after any change in administration or management of a facility. Such management changes are not infrequent and we do not feel that our staffing levels could regularly permit such frequent visits. We recommend it be discretionary with the state survey agency as to whether or not they identify the need for a survey based upon changes in administration, management or ownership.

We are seriously concerned about the administrative penalties that are proposed for inadequate state survey performances. The Health Care Financing Administration currently has and exercises the authority to deny FFP when facilities are found to have been improperly certified either procedurally or interpretively. This federal "look-behind" authority is currently the subject of numerous appeals and often results from interpretive differences between state survey agencies and the Health Care Financing Administration—which further reinforces our recommendation for additional statutory and regulatory clarification of many of the provisions contained in this bill. The proposed penalty formula would severely restrict the ability of a state survey agency to continue to conduct appropriate certification activities. We firmly believe that state survey agencies have been, are and will continue to make dedicated efforts to survey and assure compliance with federal regulatory requirements. Federal validation surveys suggesting less than acceptable state survey performance should trigger increased federal managerial and administrative assistance to the state survey agency not the imposition of a fiscal penalty that will effectively cripple the agency and preclude its improvement.

We also note that the bill proposes to put the states at risk financially if an intermediate sanction is imposed and the facility does not come into compliance during the three month period of that sanction. We feel this is an inappropriate approach. When a facility is found not to be in compliance but its noncompliance does not immediately threaten the health and safety of its residents, the imposition of an intermediate sanction short of termination appears to be an appropriate strategy. In such a case, the state, in addition to identifying the items of noncompliance, would receive from the facility a Plan of Correction to remedy those identified defects. Further, the state would be responsible for properly monitoring the facility during the period of imposition of the intermediate sanction. While the state can assume its reponsibility, it nonetheless requires the facility to operate in a good-faith relationship. If, during or at the end of the period of the intermediate sanction the facility is found to be unable or unwilling to remedy its regulatory deficiencies, it does not seem appropriate to penalize the survey agency for such a failure. Rather, the penalty should rightly be against the facility by means of denial of FFP for the support of the Medicaid patients in the facility during that time frame. We strongly urge the Subcommittee to reconsider the current language in HR 2270 as it regards this matter.

We support the proposal to eliminate the mandatory conduct of the inspection of care process separate from the survey and certification activities. At the same time, we support the proposal to permit states to continue to do inspection of care activities at their discretion. We have previously commented on and supported the requirement for preadmission screening of mentally retarded and mentally ill individuals. We would also suggest that preadmission screening authorization for Medicaid reimbursement should be applied to all nursing home residents.

In HR 2270, we note two sections wherein the Secretary has the authority to grant waivers regarding registered nurse services and Life Safety Code compliance requirements. We recommend that the states be given this waiver authority since the state survey agencies, utilizing other available state agency resources, are in the best position to make informed decisions on these potential waiver requests.

HR 2270 makes a reference to surveyor inconsistencies and mandates the states to address this issue. While we recognize that there is inter-observer variation at the state level, we would also suggest the problem exists at the national level. Since the Medicaid program is essentially a national program with significant federal financial commitment, we recommend that the Secretary be charged to identify areas of inconsistency and to develop and assist the states in implementing programs to reduce such inconsistencies. To leave such responsibility at the state level does not address the greater concern.

In summary, Mr. Chairman, we commend you, Mr. Dingell, and the other sponsors of HR 2270 for the commitments you have made and which are embodied in this proposed legislation. We believe it represents a sincere desire on your part to address the needs of our elderly population in need of certain institutional health care services and we believe that the legislation, as proposed, represents a great step forward. We sincerely appreciate the opportunity to provide these comments and trust that they will be considered along with those of the presenters at your hearing on May 12, 1987. We are prepared to pledge our organizational and individual support and assistance as you, the Subcommittee, the larger Committee, and the Congress further debate these issues.

Sincerely yours,

Richard D Yerian DO

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Vice President and
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cc: Mr. Andy Schneider
Ms. Ruth Katz

OXFORD LANE NURSING CENTER

May 21, 1987

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Honorable Henry Waxman
Chairman
Subcommittee on Health & Environment
Committee on Energy & Commerce
Room 2415
Rayburn Health Office Building
Washington, DC  20515

ATTENTION: Randy Schneider

Dear Representative Waxman:

I am president of Oxford Lane, Ltd., which owns and operates Oxford Lane Nursing Center.* I recently reviewed a transcript of the testimony of Ms. Sue Mettel given on May 12, 1987 before the House Select Committee on Aging. Ms. Mettel's testimony concerned Oxford Lane. Unfortunately, it contains numerous inaccuracies and omissions which create a general false impression about the quality of services and care provided at Oxford Lane. In sum, Ms. Mettel told only a small part of the Oxford Lane story. I wish to take this opportunity to correct the inaccuracies and omissions of Ms. Mettel's testimony and tell the whole story of Oxford Lane.

Ms. Mettel's testimony mentions that the Illinois Department of Public Health found deficiencies at Oxford Lane during several surveys in 1986. She appended to her written testimony several reports of Illinois Department of Public Health surveys. However, she did not append more recent reports that are favorable to Oxford Lane and show our compliance with applicable regulations.

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* Oxford Lane recently changed its name to Alden Nursing Center of Naperville.

EXCELLENCE
IN GERIATRIC
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AND POST OPERATIVE
NURSING SERVICES

APPROVED BY
JOINT COMMISSION
ON ACCREDITATION
OF HOSPITALS

AN ILLINOIS
CORPORATION

We do not deny that in the past Oxford Lane experienced some problems in providing the type of quality care that we believe our residents deserve. In September of 1986, the Illinois Department of Public Health conducted a licensure and certification inspection survey of Oxford Lane. That survey found a number of deficiencies in nursing services being received by residents of Oxford Lane. As a result of that survey, a Plan of Correction was prepared to correct the deficiencies noted in the survey. The deficiencies noted in the September, 1986 survey resulted primarily from inadequacies in staff performance. At no time did the Illinois Department of Public Health inform the management of Oxford Lane that an emergency existed at the facility.

Since the September, 1986 survey, Oxford Lane has taken extensive measures to correct the deficiencies found in the survey. Those measures include:

- Replacing approximately 60% of the Oxford Lane staff;
- Replacing the Nursing Home Administrator;
- Replacing the Director of Nursing;
- Replacing the Assistant Director of Nursing;
- Replacing several supervising nurses;
- Replacing the Admissions Director;
- Replacing the Business Manager;
- Replacing the Social Services Director;
- Replacing the Resident Care Coordinator;
- Replacing the Housekeeping Director; and
- Replacing nurses who failed to meet the standards deemed appropriate by Oxford Lane.

Oxford Lane has trained and supervised the new staff members and has worked to integrate them in a cohesive team to provide quality care to Oxford Lane residents. To this end, Oxford Lane hired an outside Nurse Consultant to oversee the

Nursing Department and work with the Nursing Director and Administrator.

In November, 1986 and December, 1986, Oxford Lane was resurveyed by the Illinois Department of Public Health. Those resurveys showed that some deficiencies were corrected, but some remained. The surveys also showed that acceptable progress was being made to correct remaining deficiencies.

On March 25 and 26, 1987, the Illinois Department of Public Health again resurveyed Oxford Lane. That resurvey involved an extensive review of the deficiencies found in the September, 1986 survey, as well as any deficiencies noted in the November and December, 1986 resurveys. The results of the March, 1987 survey show that Oxford Lane has complied substantially with the Plan of Correction and corrected all but three of the deficiencies noted in the original September, 1986 survey. Those three remaining deficiencies were not of a nature that they created an immiment threat to the life or health of any resident. Two of the deficiencies concerned documentation and the third concerned a single incident in which a dosage of medication was administered one hour after the appropriate time for administering the medication. Oxford Lane has already taken steps to remedy those deficiencies.

Ms. Mettel states on pages five through seven of her testimony that the Oxford Lane Family Council hired private legal counsel to petition the Du Page County Circuit Court for the appointment of a receiver. She further states that through the Family Council's effort, the State appointed a monitor to Oxford Lane. This is a gross misstatement of fact.

It is true that the Family Council did hire a private attorney to bring a lawsuit seeking the appointment of a receiver. Once that lawsuit was filed, Oxford Lane voluntarily agreed to the appointment of a monitor to periodically inspect the facility over a period of approximately 30 days and then report the findings of that inspection to the Du Page County Circuit Court. The monitor was appointed and did report her findings to the court. The monitor's report was favorable to the facility. Her findings showed that Oxford Lane is in compliance with the applicable Department of Public Health regulations. In essence, the monitor's report contradicts the entirety of Ms. Mettel's testimony. A copy of the summary of the monitor's report is attached. You will note that the monitor reported to the Du Page County Circuit Court on May 8, 1987. Ms. Mettel should have been aware of the favorable findings of the monitor prior to her May 12, 1987 testimony.

On page three and four of Ms. Mettel's testimony, she lists what she terms several "specific incidents experienced by members of the counsel." I feel that it is necessary to comment on each of these.

First, Ms. Mettel states a resident was observed handcuffed as a form of punishment. I can say without hesitation that it is not the policy of Oxford Lane to handcuff residents for any reason. I am unaware of any incident in which a resident was handcuffed. If, in fact, such an incident did occur, the employee responsible would be fired on the spot.

Second, Ms. Mettel states that on another occasion, a resident was strapped down with tight restraints so that an orderly could trim her nails and as a result, the resident was bruised on her forearms. I am unaware of the specific incident to which Ms. Mettel is referring. However, on occasion, it may be necessary to trim a resident's nails for the resident's own safety. If the resident is violent, it may be necessary that she be restrained during the period during which her nails are trimmed. On any such occasion, great care would be taken to assure the safety and comfort of the resident.

Third, Ms. Mettel states that a resident was forced to spend an evening with a resident who had died in the bed next to her. I believe the occurrence to which Ms. Mettel is referring involved a situation in which a resident did die during the course of the evening and the body could not be moved until the doctor pronounced the resident dead. The body did not remain in the room for an unnecessarily lengthy period of time and the staff did not "constantly remind" the roommate of the other resident's death.

Fourth, Ms. Mettel alleges that a resident recently had her leg amputated due to complications with an infected bed sore and malnutrition. Again, Ms. Mettel fails to identify the resident. Without qualification, we deny that any amputation has occurred due to the fault of any Oxford Lane staff. The Oxford Lane staff is aware of the potential problems that can be caused by bed sores and makes every effort to ensure that they are prevented or treated properly once detected.

Fifth, Ms. Mettel alleges that two residents died in December and February due to dehydration and states that the Oxford Lane administrator told her that IV's were being pulled due to staff shortages. IV's were never being pulled from residents in need of them due to staff shortages or for any other reason. Again, Ms. Mettel does not refer specifically to any resident. However, the deaths to which I suspect she is referring, were not the result of dehydration.

Finally, Ms. Mettel states that a family member noticed a lump on a resident's abdomen which eventually developed into cancer without any treatment by the facility. Again, Ms. Mettel does not identify the resident and we are unaware of to whom she is referring. However, I can state that every effort is made to assure that residents receive proper medical care and any incident such as this would have been called to my attention.

Ms. Mettel states that Oxford Lane is indifferent to the concerns of the families of residents. This is utterly false. Oxford Lane encouraged the development of a Family Council and the management frequently encourages open communication between the Council and management.

Ms. Mettel further alleges that Oxford Lane attempted to recruit members of the family counsel as volunteers for the Oxford Lane facility. She states that the reason for this recruitment was "to increase the facilities' reimbursement according to State Medicaid Program guidelines." This allegation is proposterous. Oxford Lane never undertook to recruit any volunteers from the Family Council for any reason other than to foster a warm relationship between the residents and their families and to improve the care and comfort of Oxford Lane residents. Moreover, the use of volunteers would have no impact on the facility's reimbursement.

Ms. Mettel finally alleges that skilled care residents are in danger of being moved from the facility due to the loss of Medicaid payments. Oxford Lane has represented to the residents, their families, and the Du Page County Circuit Court, that it will not transfer any skilled care residents from Oxford Lane due to the government's nonpayment of Medicaid reimbursement payments notwithstanding the residents' ability to compensate for the loss of Medicaid reimbursement payments by the government. This representation was made more than a month before Ms. Mettel's testimony.

In sum, Oxford Lane is committed to providing quality care to all its residents. It has acted to conform its operations to comply with all applicable state and federal regulations.

I appreciate this opportunity to complete the story of Oxford Lane. If the committee desires, I would be pleased to testify and provide you with a broader perspective of Oxford Lane and the nursing home industry than that which was provided by the testimony of Ms. Mettel.

Very truly yours,

Floyd Schlossberg

## SUMMARY OF MONITOR'S REPORT
## OXFORD LANE
## 4/13, 4/15, 4/21, 4/22, 4/27, 5/1, 5/3, & 5/4/87

Monitor did not observe any patterns of poor care, negligence in nursing care or life threatening situations while at Oxford Lane for 8 visits. It is the impression of this monitor/HFSN that the new management team - Administrator, Director of Nurses, Assistant Director of Nurses, Supervisor - have and are continuing to observe and identify problems/ needs in this facility and are making a concerted effort to correct past problems at this time. Comments to monitor by residents and visitors were of a positive nature regarding changes they can see and the availability of staff, as well as the attitude of staff.

Respectfully submitted:

Karen Atkins RN

Karen Atkins, RN

KA/cg